

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5729

CERTIFICATE OF DEATH

Reg. Dist. No.

05704

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 14141 Layhill Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Palmer		First Eddy	Middle 	Last Allen	4. DATE OF DEATH Month May	Day 5	Year 19 59
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 4.1.88	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Hours
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Policeman		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Palmer A. Allen				14. MOTHER'S MAIDEN NAME Callie Summers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT Address Hospital Records,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus INTERVAL BETWEEN ONSET AND DEATH 3 hours DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aneurism Aorta 8 years DUE TO (c) Atherosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sandy Spring, Md.		20f. (City or town) (County) (State) Sandy Spring, Md.	
21. I certify that I attended the deceased from 4/3/59 to 5/5/59 , 1959, that I last saw the deceased alive on 5/4/59 , 1959, and that death occurred at 8:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE R. W. Bird ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 5/5/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7-59		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery, Gaithersburg, Md.		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Summer & Brothers		ADDRESS 1661-97 Hager		24a. REC'D BY REGISTRAR DATE MAY 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

81 2945144 - HTL 1890 THIRTY NINE HUNDRED EIGHTY ONE
HTL 1890 STADTBERG

Item 18, Part MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

I & II 7/6/59 RS Film # C 244

05705

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		5730	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 3636 16th St., N.W. - Apt. B633			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Albert	Middle Herman	Last ARONSON	4. DATE OF DEATH	Month May	Day 12	Year 1959	
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3-1-66	9. AGE (In years last birthday) 93	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT (D) Miss Alice H. Aronson, same as #2 above		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)		153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Peritonitis, Acute, generalized Adenocarcinoma, ascending colon with perforation into the peritoneal cavity		INTERVAL BETWEEN ONSET AND DEATH 5 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Myocardial infarction; Arteriosclerotic Heart Disease				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month May	Day 10	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) U. S. Naval Hospital, NNMC	(County) Denver	(State) Colorado
21. I certify that I attended the deceased from May 10 , 1959, to May 12 , 1959, that I last saw the deceased alive on May 11 , 1959, and that death occurred at 12:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC									
ACTUAL SIGNATURE <i>M. C. Shea</i>		DATE SIGNED 5-12-59							
PHYSICIAN'S NAME (Type) M. C. SHEA, Lieutenant, MC, USN		B. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 5-13-59							
22b. DATE THEREOF 5-13-59		22c. NAME OF CEMETERY OR CREMATORIAL Fairmount Cemetery		22d. LOCATION (City, town, or county) Denver		(State) Colorado			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Funeral Home, Bethesda, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur & Anna</i>			

2025 RELEASE UNDER E.O. 14176

HEAD TO BACK

2025 RELEASE UNDER E.O. 14176

2025 RELEASE UNDER E.O. 14176

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5731 CERTIFICATE OF DEATH

Reg. Dist. No. 05706

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Bethesda 5 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS 2600 ELMONT ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First HATTIE	Middle ESTELLE
4. DATE OF DEATH		Month MAY	Day 21
5. SEX FEMALE		6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7/3/90		9. AGE (in years at death) 68 yrs.	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) WASH. D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM. E RANDALL	
14. MOTHER'S MAIDEN NAME MAY . DAVIS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT Mr. Harry S. Aubinoe, 2600 Elmont St., Wheaton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Secondary condition of the 420.1 and the cause of death. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 19</u> , 19 <u>59</u> , to <u>May 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>59</u> , and that death occurred at <u>2600 Elmont St.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE George A. GRAHAM, M.D. PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) 104 Chevy Chase Dr., Chevy Chase 15, Md. DATE SIGNED 5/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/25/59	22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY
22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MD.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. G.		24a. REC'D BY REGISTRAR MAY 26 '59	24b. REGISTRAR'S SIGNATURE Arthur & Anna
RP		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be left with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

WILLIAMSON COUNTY TEXAS

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5710 CERTIFICATE OF DEATH

Reg. Dist. No.

05707

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
f. STREET ADDRESS 12,022 BLUHILL ROAD		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle ANDREW Last Austin		4. DATE OF DEATH May 25 1959	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER OF MARKET		10b. KIND OF BUSINESS OR INDUSTRY MARKET	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES R. AUSTIN		14. MOTHER'S MAIDEN NAME CINNIE WAGES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 243-24-7194	
17. INFORMANT Mrs. Ramona H. Austin, 12,022 Bluhill Road, Silver Spring, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.0		INTERVAL BETWEEN ONSET AND DEATH 1 day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		7 days (c) DUE TO	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 1959, to 5/24 1959, that I last saw the deceased alive on 5/24/59, 1959, and that death occurred at 8 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE CHARLES M. WEBER		ADDRESS (Street, city or town, state) 12600 PARKLAWN DRIVE ROCKVILLE, MARYLAND DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/27/59	
22c. NAME OF CEMETERY OR CREMATORIAL PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. FUMPHREY INC. Dawnard A. Biakai		24a. REC'D BY REGISTRAR DATE MAY 27 '59	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Hayes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

17. 2018年1月1日，甲公司购入乙公司30%的股权，可对乙公司实施重大影响。

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5732

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH
Reg. Dist. No. 05708

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 145 mins.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ivy	Middle (Iris)	Last Bauer
4. DATE OF DEATH	Month May	Day 7	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1905
9. AGE (In years last birthday) 54 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician	11. KIND OF BUSINESS OR INDUSTRY Foxhall Beauty Shop	12. BIRTHPLACE (State or foreign country) Balto. Md.
13. FATHER'S NAME George E. Wayson	14. MOTHER'S MAIDEN NAME Mary L. Hudson	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 578 03 1040 Mrs. Richard Bentz, 2814 Cheswold Rd.	
16. SOCIAL SECURITY NO.		INFORMANT	Address
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/4 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/5 , 1959, to 3/7 , 1959, that I last saw the deceased alive on 5/7 , 1959, and that death occurred at 11:15 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Allen J. O'Neill, M.D., 8601 Old Georgetown Rd., Bethesda, Md.	
ACTUAL SIGNATURE Allen J. O'Neill, M.D.		DATE SIGNED 1959	
PHYSICIAN'S NAME (Type) Glen Haven		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 12/59	
23. FUNERAL DIRECTOR'S SIGNATURE Witke Funeral Directors		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Glen Haven	
4101 E. Maryland Ave.		24a. REC'D BY REGISTRAR DATE MAY 11 '59	
dmo		24b. REGISTRAR'S SIGNATURE Arthur S. Traub	

SEARCHED INDEXED SERIALIZED FILED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5733 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Germany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY	
c. LENGTH OF STAY IN lb <i>19 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Weinheim</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>12921 Matij Rd</i>		d. STREET ADDRESS <i>8 Markt Platz</i>	
3. NAME OF DECEASED (Type or print) <i>Eugen</i>		First <i>HERMANN</i>	Middle <i>Bauerle</i>
4. DATE OF DEATH <i>May 23 1959</i>		Last <i>BAUERLE</i>	Month <i>May</i>
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>Sept 9 1884</i>
9. AGE (In years last birthday) <i>74</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dentist (Dental Surgeon)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own business</i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>Germany</i>	
13. FATHER'S NAME <i>Wilhelm Bauerle</i>		14. MOTHER'S MAIDEN NAME <i>MARIA BAUR</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>111-11-1111</i>	
17. INFORMANT <i>Elmer A. Barker - Daughter - Stein</i>		Address <i>123 Sudden</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>White at work</i>	
20c. TIME OF INJURY Hour <i>a. m.</i> <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>None</i>		(County) <i>None</i>	
		(State) <i>None</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		DATE SIGNED <i>5-23-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRAN.S. & BURIAL <i>5/25/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>GERMAN WAR VETERANS CEMETERY</i>	
		22d. LOCATION (City, town, or county) <i>CHICAGO ILLINOIS</i>	
		(State) <i>None</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey Inc.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 26 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur & Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

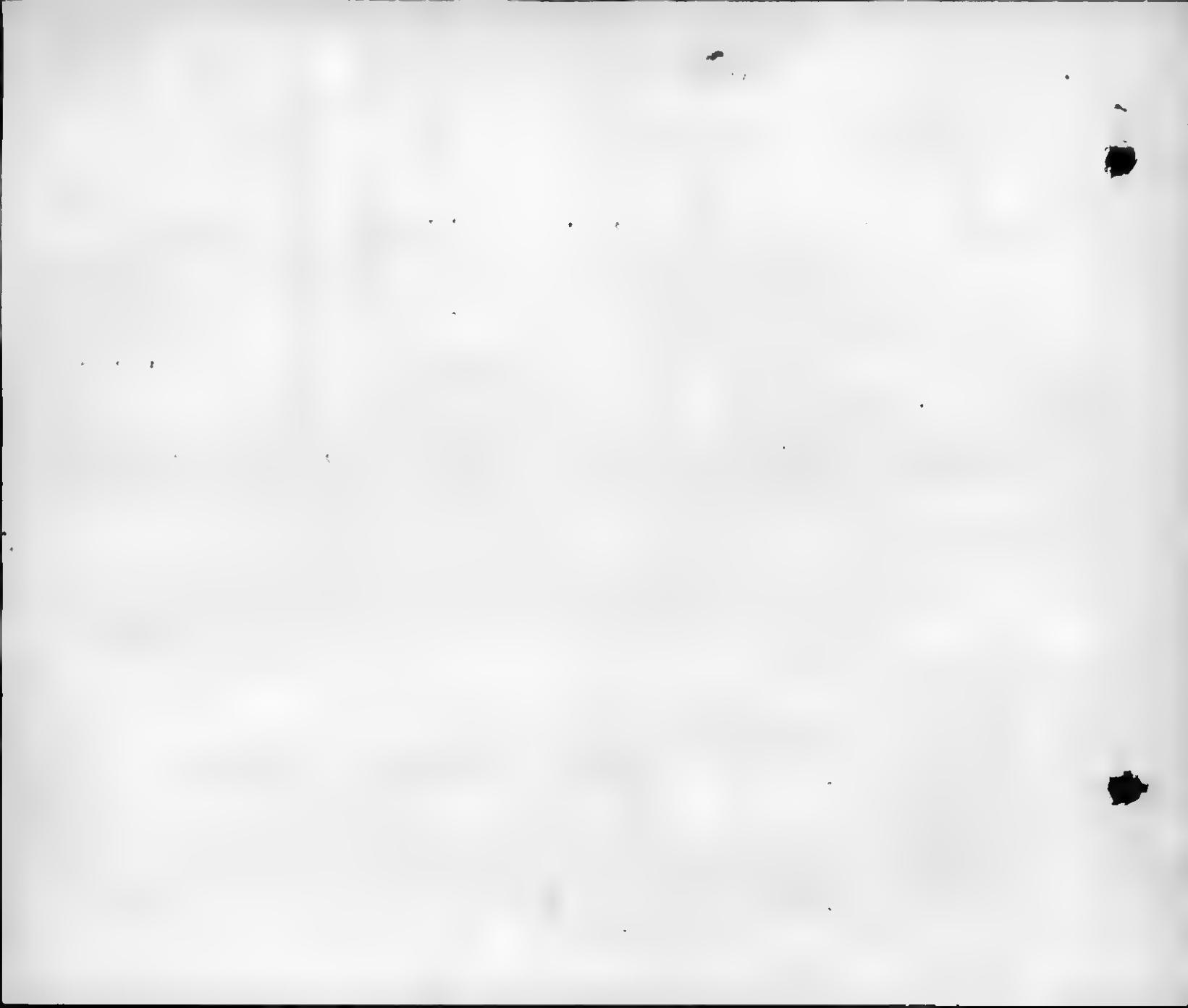
5734 CERTIFICATE OF DEATH

Reg. Dist. No.

05710

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Florida		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Atlantic Beach		41		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS P.O. Box 1782		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH May	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 6, 1911	9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian		10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME John C. Borden		14. MOTHER'S MAIDEN NAME Sarah Smith						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO 41 x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Rheumatic Heart Disease with mitral stenosis and mitral insufficiency				INTERVAL BETWEEN ONSET AND DEATH years		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Severe emphysema				6 days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from May 3, 1959, to May 25, 1959, that I last saw the deceased alive on May 25, 1959, and that death occurred at 10:02 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) William P. Cornell M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 5-25-59								
ACTUAL SIGNATURE William P. Cornell		PHYSICIAN'S NAME (Type) William P. Cornell, M.D.						
22a. BURIAL, CREMATION, OR TRANSPORTATION Burial 5/25/59		22b. DATE THEREOF 5/25/59		22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery		22d. LOCATION (City, town, or county) Jacksonville Florida (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		7557 Adair Ave Bethesda		24a. REC'D. BY REGISTRAR MAY 28 1959		24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey		
VS A15 (4) 15M 10/57				DATE				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5711

CERTIFICATE OF DEATH

Reg. Dist. No.

05711

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14Koma Park		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		d. STREET ADDRESS 6616 24th Ave			
d. NAME OF HOSPITAL (If not in hospital, give street, address) OR INSTITUTION Washington Sane Hospital				d. STREET ADDRESS 6616 24th Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Victoria Cone		First	Middle	Last	4. DATE OF DEATH May 3 1959	Month	Day	Year	
5. SEX fe		6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-15	9. AGE (In years at death) 43 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Typist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Joseph MacGalliard		14. MOTHER'S MAIDEN NAME Elizabeth Cone							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post Hemorrhagic hepatic coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Cirrhosis of the liver DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 6826 Piggott, Hyattsville, Md.	20f. (City or town) Portsmouth	(County) Virginia	(State)
21. I certify that I attended the deceased from alive on		5/2 1959		4/30 1959 to 5/3 1959		that I last saw the deceased and that death occurred at 5:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) H. WAYNE GLICKFIELD, M.D.						ADDRESS (Street, city or town, state) M.D. 6826 Piggott, Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/5/59		22c. NAME OF CEMETERY OR CREMATORIUM Oak Grove Cemetery		22d. LOCATION (City, town, or county) Portsmouth, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Finch C. 2901-14		ADDRESS 6028 1/2 N. 10th St.		24a. REC'D BY REGISTRAR MAY 5 '59		24b. REGISTRAR'S SIGNATURE Clothing & Travel			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5735 CERTIFICATE OF DEATH

Reg. Dist. No. 05712

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boyds</i>	c. LENGTH OF STAY IN lb <i>9 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boyds</i>	d. STREET ADDRESS <i>Route 2</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Montgomery Co. Gen. Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Clara</i>	First <i>Jane</i>	Middle <i>Boone</i>	4. DATE OF DEATH Month <i>May</i> — Day <i>2</i> Year <i>1959</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec-12-1879</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic nursing</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>nursing</i>	9. AGE (in years, last birthday) <i>79</i> yrs		
10c. FATHER'S NAME <i>William Columbus Bradford</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] [If yes, give war or dates of service]		14. MOTHER'S MAIDEN NAME <i>Mary Jane Hilla Ray</i>	Address <i>Eleanor King R-2-Boyds, Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7-Brooks Ave.</i>	20f. (City or town) <i>Cedar Grove</i>	(County) <i>Maryland</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>April-14-1959</i> to <i>May-2-1959</i> that I last saw the deceased alive on <i>May-1-1959</i> , and that death occurred at <i>8:20 AM</i> M, from the causes and on the date stated above ACTUAL SIGNATURE <i>William C. Miller</i> M.D. ADDRESS (Street, city or town, state) <i>7-Brooks Ave., Gaithersburg, Md</i> DATE SIGNED <i>May 6 1959</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-5-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Upper Seneca Baptist Ch</i>	22d. LOCATION (City, town, or county) <i>Cedar Grove</i>	(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest L. Hartman, Gaithersburg Md</i>			ADDRESS <i>Ernest L. Hartman, Gaithersburg Md</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 6 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

200" to 1131-21 324

421. ~~Scutellaria~~ ~~leaves~~ ~~green~~ ~~green~~ ~~green~~

422. ~~Scutellaria~~ ~~leaves~~ ~~green~~ ~~green~~ ~~green~~

423. ~~Scutellaria~~ ~~leaves~~ ~~green~~ ~~green~~ ~~green~~

424. ~~Scutellaria~~ ~~leaves~~ ~~green~~ ~~green~~ ~~green~~

425. ~~Scutellaria~~ ~~leaves~~ ~~green~~ ~~green~~ ~~green~~

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05713

5736

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		d. STREET ADDRESS Rt. #3, Box 338	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Baby Randolph	Middle N.	Last BOWMAN	4. DATE OF DEATH	Month May	Day 1	Year 19 59
5. SEX Male	6. COLOR OR RACE Caucasian	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-29-59	9. AGE (In years last birthday) yrs	10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS Days 2	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. BOWMAN				14. MOTHER'S MAIDEN NAME Jeanette V. BLOMQVIST			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO <i>1-45</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congenital</i> DUE TO <i>Disease</i> (c) <i>3 days</i> INTERVAL BETWEEN ONSET AND DEATH <i>missed</i> .							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1959, to May 1, 1959, that I last saw the deceased alive on May 1, 1959, and that death occurred at 5:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>David Harris</i> M.D. U. S. Naval Hospital, NNMC 5-2-59							
PHYSICIAN'S NAME (Type)		David HARRIS, LT, MC, USN		Bethesda 14, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4-59		22c. NAME OF CEMETERY OR CREMATORIUM Glen Haven Cemetery		22d. LOCATION (City, town, or county) Glen Burnie (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Singleton Funeral Home, Glen Burnie, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 6 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5737 CERTIFICATE OF DEATH

05714

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 59 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		d. STREET ADDRESS 7220 Everglades Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma		First	Middle	Lost	4. DATE OF DEATH May	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-05	9. AGE (In years lost birthday) 53	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Radcliff			14. MOTHER'S MAIDEN NAME Elizabeth Stevenson			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown			16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>153.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Squamous cell carcinoma, uterus</u> DUE TO (c) <u>Adenocarcinoma, colon</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH 4 mos									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>March 13</u> , 19 <u>59</u> , to <u>May 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 11</u> , 19 <u>59</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>C. M. Garland Jr.</u> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <u>C. M. GARLAND, JR., CDR, MC, USN</u> <u>Bethesda 14, Maryland</u> DATE SIGNED <u>U. S. Naval Hospital, NNMC</u> <u>5-12-59</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-59	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington (State) Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers</i>		ADDRESS W. W. Chambers, 1400 Chapin St., N.W., Wash.DC	24a. REC'D BY REGISTRAR DATE MAY 14 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05715

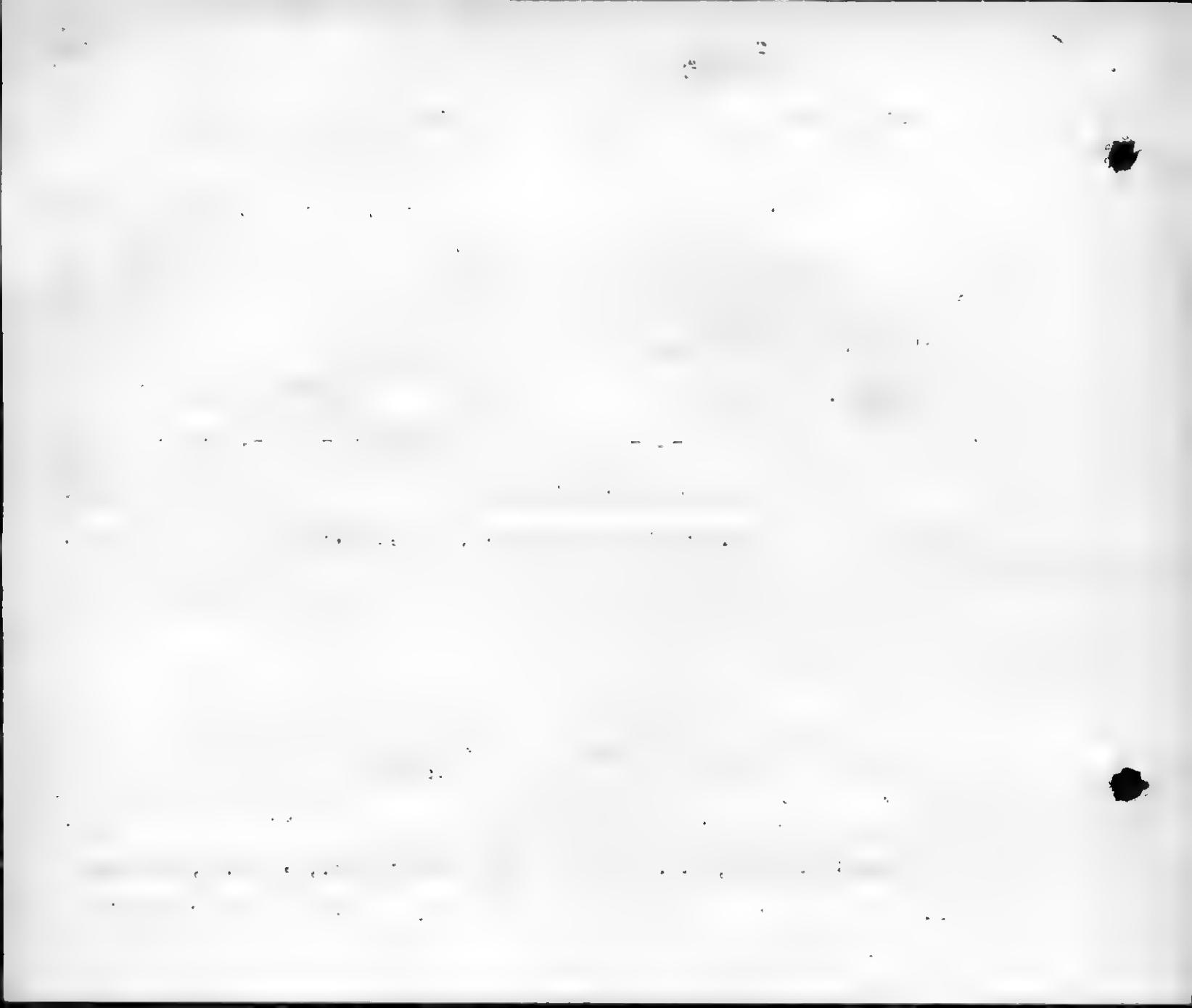
5738

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8505 Lynnbrook Drive	
3. NAME OF DECEASED (Type or print) EARL M.		4. DATE OF DEATH Month MAY Day 8 Year 1959	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12/4/1892	
9. WIDOWED <input type="checkbox"/>		10. DIVORCED <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George A. Broadhurst		14. MOTHER'S MAIDEN NAME Valie Dixon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) No		16. SOCIAL SECURITY NO. 577-26-4114	
17. INFORMANT Helen Broadhurst-wife-same as 2d		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Pulmonary embolization 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Rheumatic Heart Disease, Mitral Stenosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7 , 19 47 , to May 8 , 19 59 that I last saw the deceased alive on May 8 , 19 59 , and that death occurred at 9:55 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert G. Angle</i> PHYSICIAN'S NAME (Type) Robert G. Angle, M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 5-11-59		22c. NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery.	
22d. LOCATION (City, town, or county) Rockville, Maryland		24a. REC'D BY REGISTRAR DATE MAY 12 '59	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

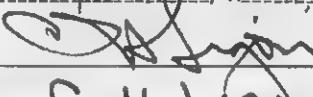
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 18-20 Film 243 6-9-59 a.m.

CERTIFICATE OF DEATH

Reg. Dist. No.

05716

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Montgomery b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN lb 17 days	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION Brooke Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring, Maryland	
3 NAME OF DECEASED (Type or print) Susan		4. DATE OF DEATH Brooks Month May Day 15 Year 19 59	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH 4/28/59	9. AGE (In years last birthday) yrs. 0 17 IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 17 Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Allen Warfield Brooks		14. MOTHER'S MAIDEN NAME Robinette Viola Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address Hospital Record, Montgomery Co. Gen. Hospital
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 921.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) DUE TO (c) DUE TO Strangulation Aspiration of stomach contents INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Vomited and strangled	
20c. TIME OF INJURY Month, Day, Year Hour 3:30 5 15 1959		20d. INJURY OCCURRED While at work Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) own home 20f. (City or town) Brooke Rd. Sandy Spr. Montg. Md. (County) (State)
21. I certify that I attended the deceased from 4/28 , 1959, to 5/15 , 1959, that I last saw the deceased alive on 5/15 , 1959, and that death occurred at 5:30 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 5/17/59			
ACTUAL SIGNATURE 		M.D.	
PHYSICIAN'S NAME (Type) C. H. L. Leon			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/59	22c. NAME OF CEMETERY OR CREMATORIAL Sandy Spring
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Saunders		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE MAY 20 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Thorne



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 ☐ NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

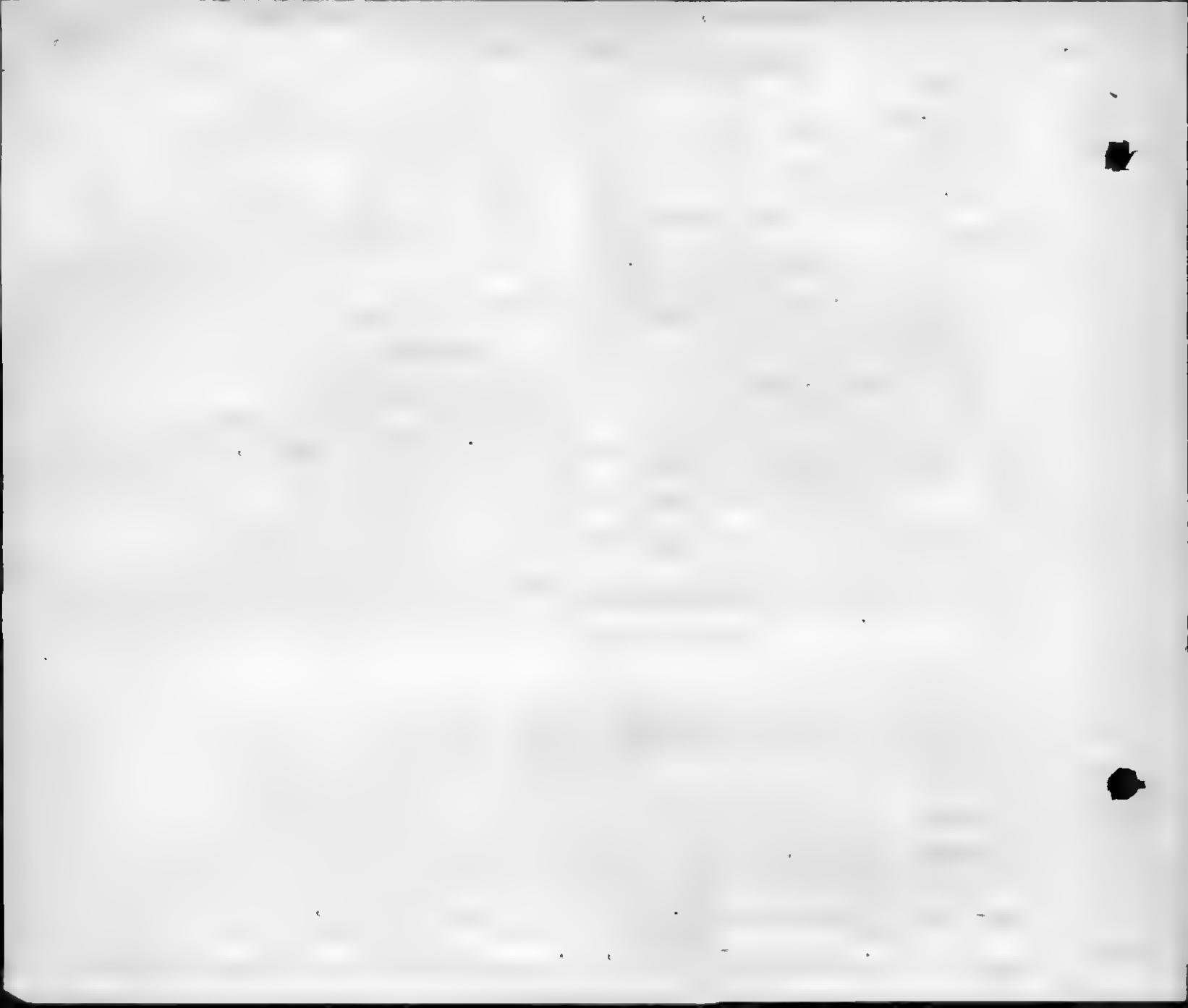
Item 1 Form 15-5-11-77 et

05717

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE New York		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		d. STREET ADDRESS 4401 Clarendon Road			
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION 9810 Georgia Avenue						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alvina G. Brown		First	Middle	Last	4. DATE OF DEATH MAY 2 1959	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH March 4, 1885	9. AGE (In years from birth) 74	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY US			
13. FATHER'S NAME Merrath Bleichner		14. MOTHER'S MAIDEN NAME Celine Oberhaseur							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Benj. Newton		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 44.00		DUE TO (b) Generalized Arteriosclerosis		DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Essential Hypertension		21. I certify that I attended the deceased from May 24, 1958 to May 2, 1959 , that I last saw the deceased alive on May 2, 1959 , and that death occurred at 7:15 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Henry M. Lowden M.D. PHYSICIAN'S NAME (Type) Henry M. Lowden			
20c. TIME OF INJURY Hour a. p.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5206 Norway Dr.		20f. (City or town) Bronx, New York		(County) Bronx	(State) New York
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF May 5/2/59		22c. NAME OF CEMETERY OR CREMATORIUM St. Johns		22d. LOCATION (City, town, or county) Bronx, New York		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DA MAY 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause			
VS 15 (4) 15M 9/55									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05718

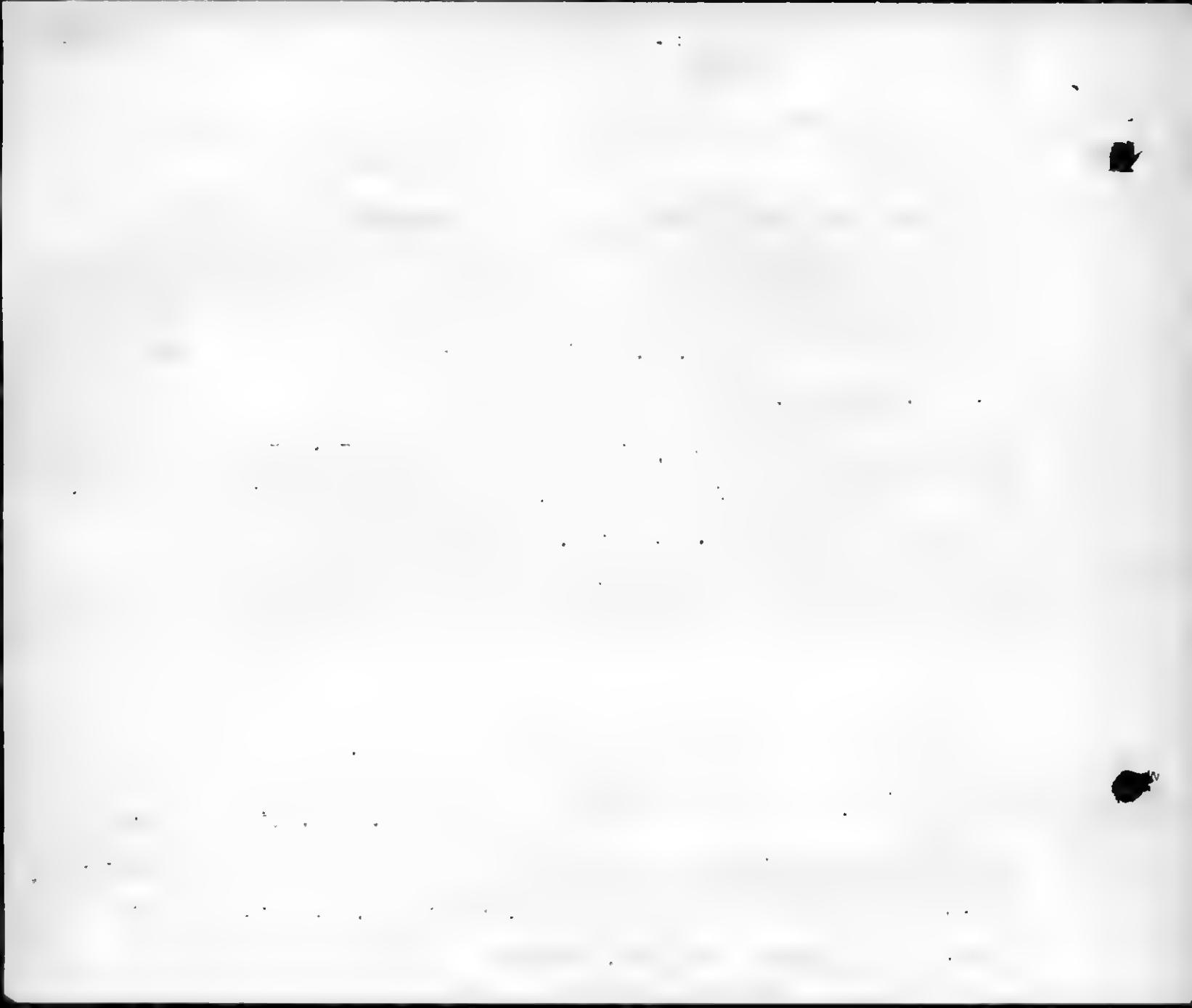
5741

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 3920 Baltimore Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3920 Baltimore Street		d. STREET ADDRESS 3920 Baltimore Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FREDERICK	First W	Middle BROWN	Last May 25 1959
4. DATE OF DEATH May 25 1959	Month May	Day 25	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/1875
9. AGE (In years last birthday) 83 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. KIND OF BUSINESS OR INDUSTRY U. S. Gov't	12. BIRTHPLACE (State or foreign country) Michigan
13. FATHER'S NAME Frederick T. Brown	14. MOTHER'S MAIDEN NAME Annie Bates		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO Yes-Unknown	INFORMANT Fannie I Brown-wife-same as 2d	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO Myocardial Infarction Coronary occlusion Coronary atherosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/20/1959 to 5/23/1959 , that I last saw the deceased alive on 5/22/1959 , and that death occurred at 12:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald Nelson		ADDRESS (Street, city or town, state) M.D. 10620 Ga. Ave. Silver Spring	
DATE SIGNED			
PHYSICIAN'S NAME (Type) Donald Nelson		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 5/27/59	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 28 '59
		24b. REGISTRAR'S SIGNATURE John & Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5742 CERTIFICATE OF DEATH

Reg. Dist. No.

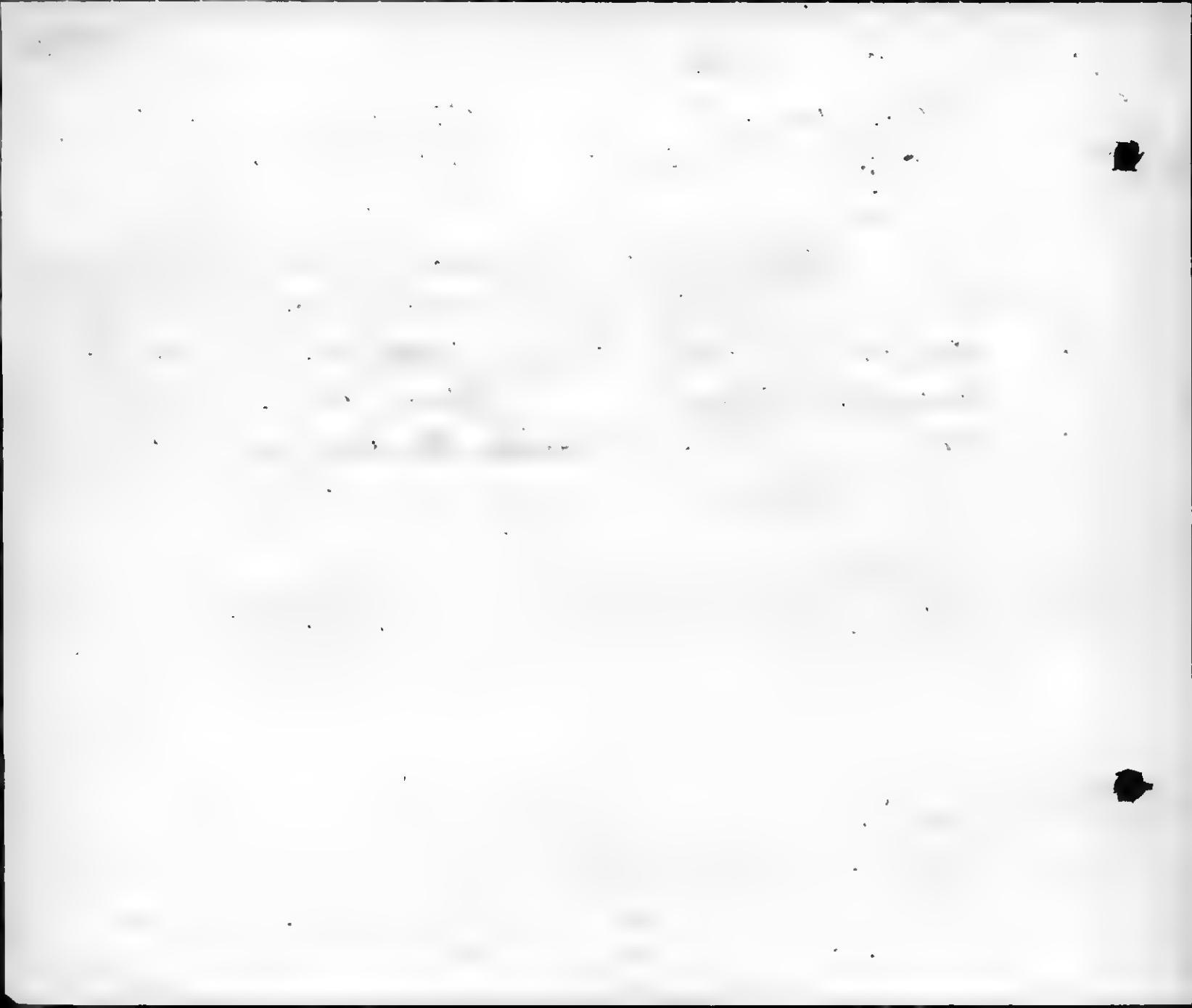
05719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has been signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>D.O.A.</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Jesse</i>	Middle <i>A.</i>	Last <i>Brown</i>					
4. DATE OF DEATH Month <i>5</i>	Month <i>26</i>	Day <i>1959</i>	Year					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 17, 1890</i>					
9. AGE (In years last birthday) 68 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Cathedral Co.</i>	12. BIRTHPLACE (State or foreign country) <i>Virginia</i>					
13. FATHER'S NAME <i>Irving A. Brown</i>	14. MOTHER'S MAIDEN NAME <i>Mary Ann Cunningham</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>						
16. SOCIAL SECURITY NO. <i>579-09-1984</i>	INFORMANT <i>Hilda Mae Newkirk</i>	17. ADDRESS <i>Daughter</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) <i>Acute Coronary Thrombosis</i> DUE TO (c) <i>Coronary Atherosclerotic Disease</i> DUE TO <i>Caeruleum Prostate bc pelvic & genitae metastases.</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Caeruleum Prostate bc pelvic & genitae metastases.</i>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Bethesda</i>	(County) <i>Montgomery</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>October</i> , 1958 to <i>May 26</i> , 1959, that I last saw the deceased alive on <i>May 14</i> , 1959, and that death occurred at <i>9:15 P.M.</i> from the causes and on the date stated above.				ACTUAL SIGNATURE <i>J. Blaine Fitzgerald</i>	M.D. <i>J. Blaine Fitzgerald</i>	ADDRESS (Street, city or town, state) <i>8218 Wisconsin Avenue</i>	DATE SIGNED <i>5/26/59</i>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/29/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) <i>Suitland, Maryland</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>	ADDRESS <i>Bethesda, Maryland</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 28 '59</i>	24b. REGISTRAR'S SIGNATURE <i>John & Koenig</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05720

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII. A1SME
5M 2/57

5743

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
a. COUNTY		a. STATE	
Montgomery		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Silver Spring		Montgomery	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
10 yrs		Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
2710 Arcola Ave		2710 Arcola Ave	
e. IS RESIDENCE ON A FARM?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First		Month	
Middle		Day	
Last		Year	
Frederick Slater Butler Jr.		May 30 1959	
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		Divorced <input type="checkbox"/>	
3-8-1927		9. AGE (In years from birthday)	
32 yrs		IF UNDER 1 YEAR	
Months Days Hours Min.		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Mantua		gas ex.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
DC		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Frederick A. Butler		Drew Brattin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
YES WW # 2		578-30-6964	
17. INFORMANT		Address	
Petition Butler (wife)		1612 2nd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED?	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
774 X		Asphyxia	
DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Sudden	
(b)		Hanging	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED?	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not w/ h of work <input type="checkbox"/> of work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. WAS AUTOPSY PERFORMED?	
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/2/59	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l. Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Raymond A. Biika		24a. REC'D BY REGISTRAR DATE JUN 2 '59	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE L. King & Kraus	



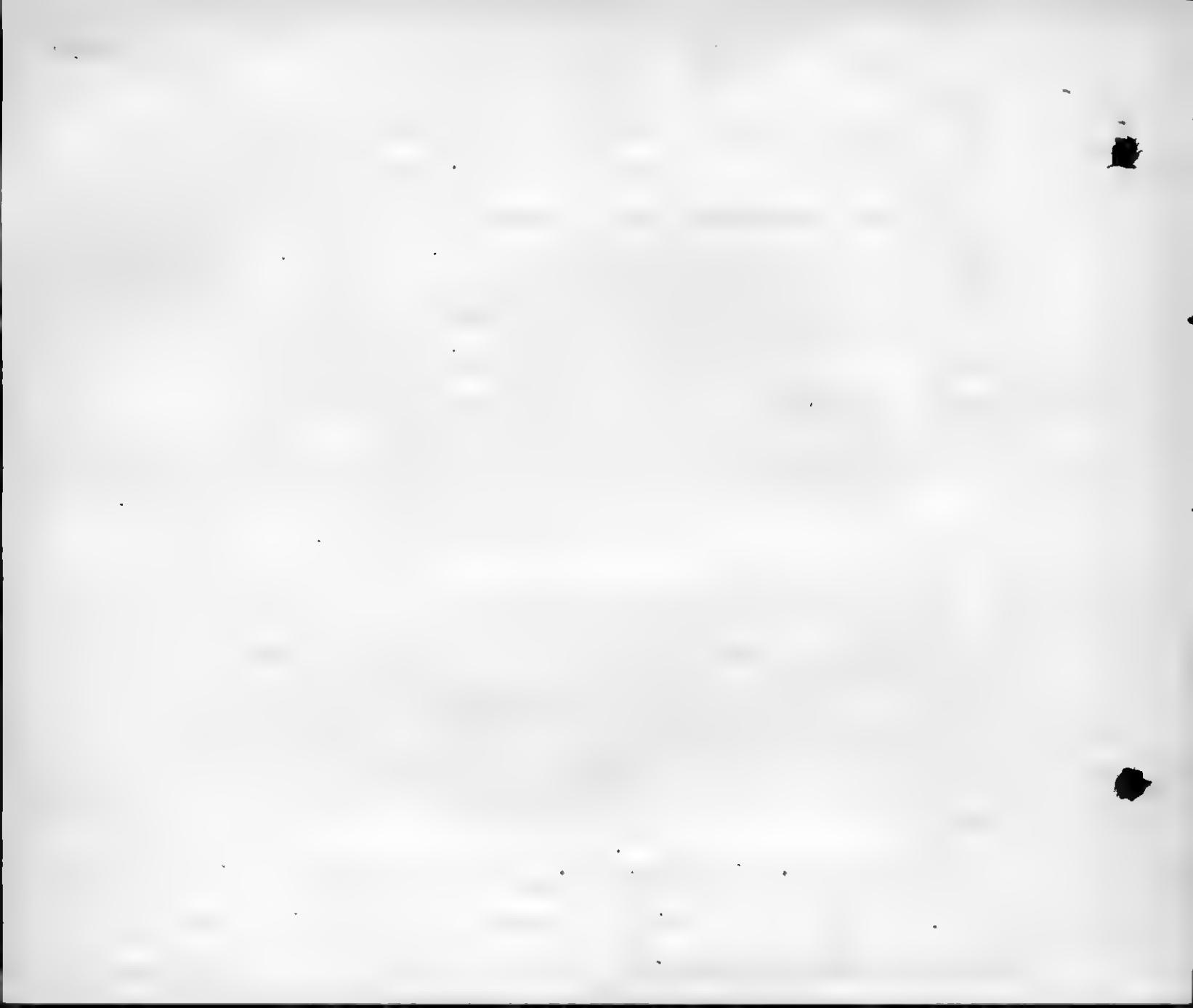
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5744 CERTIFICATE OF DEATH

Reg. Dist. No.

05721

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution- Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 43 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		d. STREET ADDRESS 914 GRANDIN AVENUE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First JOHN	Middle MAYNARD	Last CAREY	4. DATE OF DEATH MAY 23 1959	Month MAY	Day 23	Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/26/94	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR 9 Months	IF UNDER 24 HRS 27 Days	Hours Min. 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUTCHER		10b. KIND OF BUSINESS OR INDUSTRY GRAND UNION MARKET		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME JOHN RICHARD CAREY			14. MOTHER'S MAIDEN NAME MARY CATHERINE DEAN			Address OLNEY, MARYLAND		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HOSPITAL RECORDS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO GENERALIZED METABOLISM Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO CARCINOMA OF COLON (c)		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from February 23, 1959 to 23 May 1959 that I last saw the deceased alive on May 23, 1959 , and that death occurred at 2:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) GORDON S. ROSENBERGER, M.D. M.D. ACTUAL SIGNATURE Gordon S. Rosenberger DATE SIGNED 23 May 1959								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-26-59		22c. NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Arthur & Kraus		24b. REGISTRAR'S SIGNATURE Arthur & Kraus		
VS A15 (4) 1SM 10/57		DATE MAY 27 '59						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5745 CERTIFICATE OF DEATH

05722

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Route 1-Gaithersburg</i>		c. LENGTH OF STAY IN 1b <i>6 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg Maryland</i>		d. STREET ADDRESS <i>none</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William Frederick Carl</i>		First	Middle	Last	4. DATE OF DEATH MAY 12 1959	Month	Day	Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 7, 1920</i>	9. AGE (In years last birthday) <i>38 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dairymen</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dairy</i>		11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Edmund O-Carl</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Beuchert</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>578-14-4042</i>		17. INFORMANT <i>Mrs. Sarah F. Carl</i>		Address <i>Route 1-Gaithersburg</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction?</i>		DUE TO <i>Coronary Thrombosis</i>		DUE TO <i>Biliary Perforation?</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 MIN</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i>		(b)		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Sudden Death - await autopsy report</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County)	(State)
21. I certify that I attended the deceased from <i>June 8, 1956</i> to <i>12 MAY 1959</i> , that I last saw the deceased alive on <i>12 MAY 1959</i> , and that death occurred at <i>3:00 PM</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Bosley Ziegler M.D.</i>						ADDRESS (Street, city or town, state) <i>21 N EY MD</i>		DATE SIGNED <i>12 MAY 59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 15/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven</i>		22d. LOCATION (City, town, or county) <i>13705-5th ave</i>		(State) <i>Adams Spring MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Adams Funeral Home</i>		ADDRESS <i>4746 Wisconsin Avenue Washington, DC</i>		24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>			
				DATE <i>MAY 15 59</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5746

CERTIFICATE OF DEATH

Reg. Dist. No.

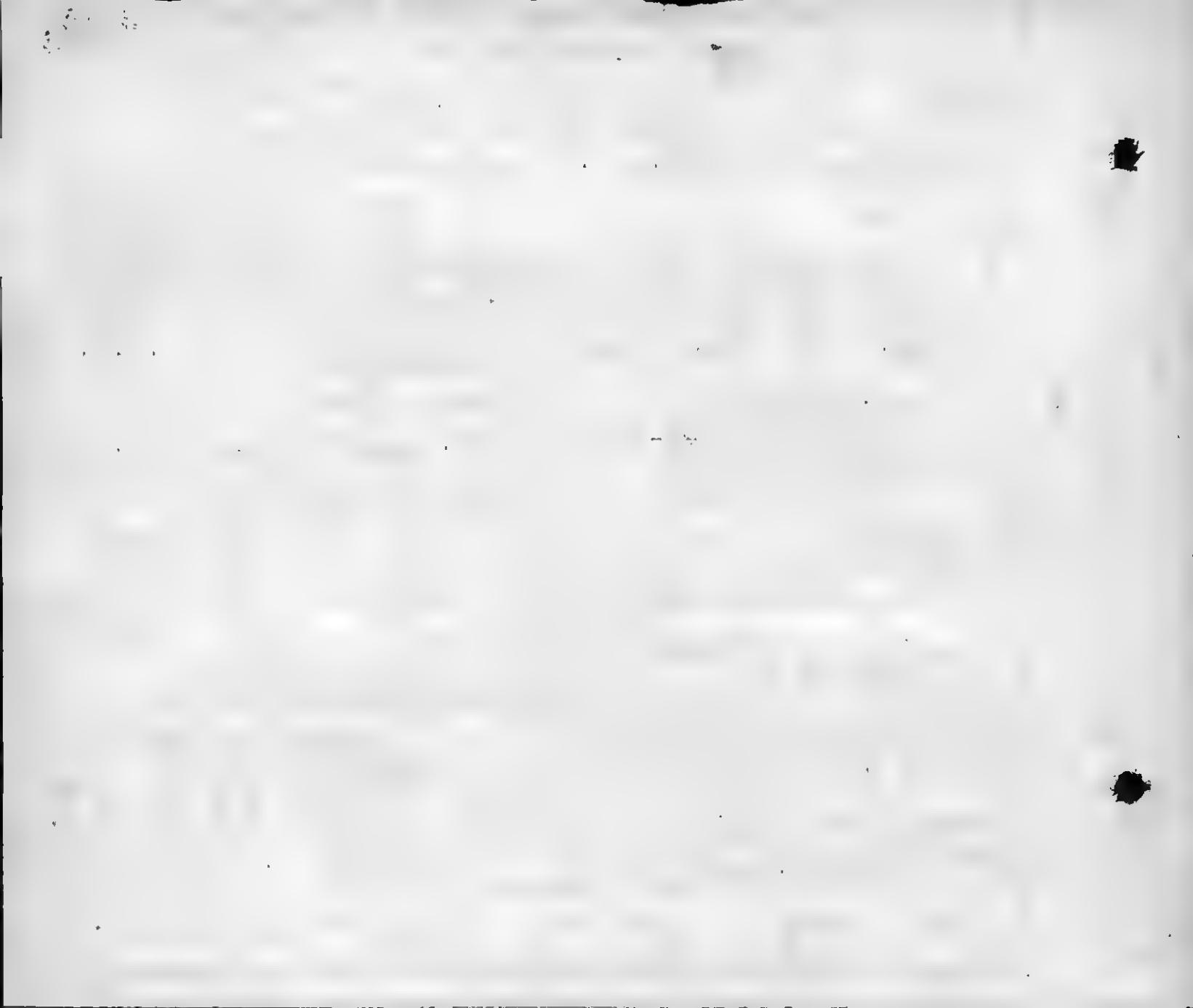
05723

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson		c. LENGTH OF STAY IN lb 70 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James Maurice		First	Middle	Lost	4. DATE OF DEATH Carlisle, Sr	Month 5	Day 19	Year 1959
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Mar. 4, 1889	9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm & Dairy		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Richard C. Carlisle		14. MOTHER'S MAIDEN NAME Frances Appleby						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No 213-38-3162		17. INFORMANT Betty C. Carlisle		Address Dickerson, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 15 minutes		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary Occlusion, acute						
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.		DUE TO (b) Coronary arteriosclerosis				2 year		
		DUE TO (c) Generalized arteriosclerosis				5 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Barnesville, Md.	(County)	(State)	
21. I certify that I attended the deceased from <u>5 Nov</u> , 1959, to <u>19 May</u> , 1959, that I last saw the deceased alive on <u>19 May</u> , 1959, and that death occurred at <u>10140 B</u> M, from the causes and on the date stated above				ADDRESS (Street, city or town, state) Barnesville, Md.		DATE SIGNED 21 May 59		
ACTUAL SIGNATURE Gordon M. Smith		M.D.						
PHYSICIAN'S NAME (Type) Gordon M. Smith				Barnesville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/22/59	22c. NAME OF CEMETERY OR CREMATORIUM Monocacy		22d. LOCATION (City, town, or county) Beallsville		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton Barnesville Md.		ADDRESS		24a. REC'D BY REGISTRAR MAY 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Tracy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5747

CERTIFICATE OF DEATH

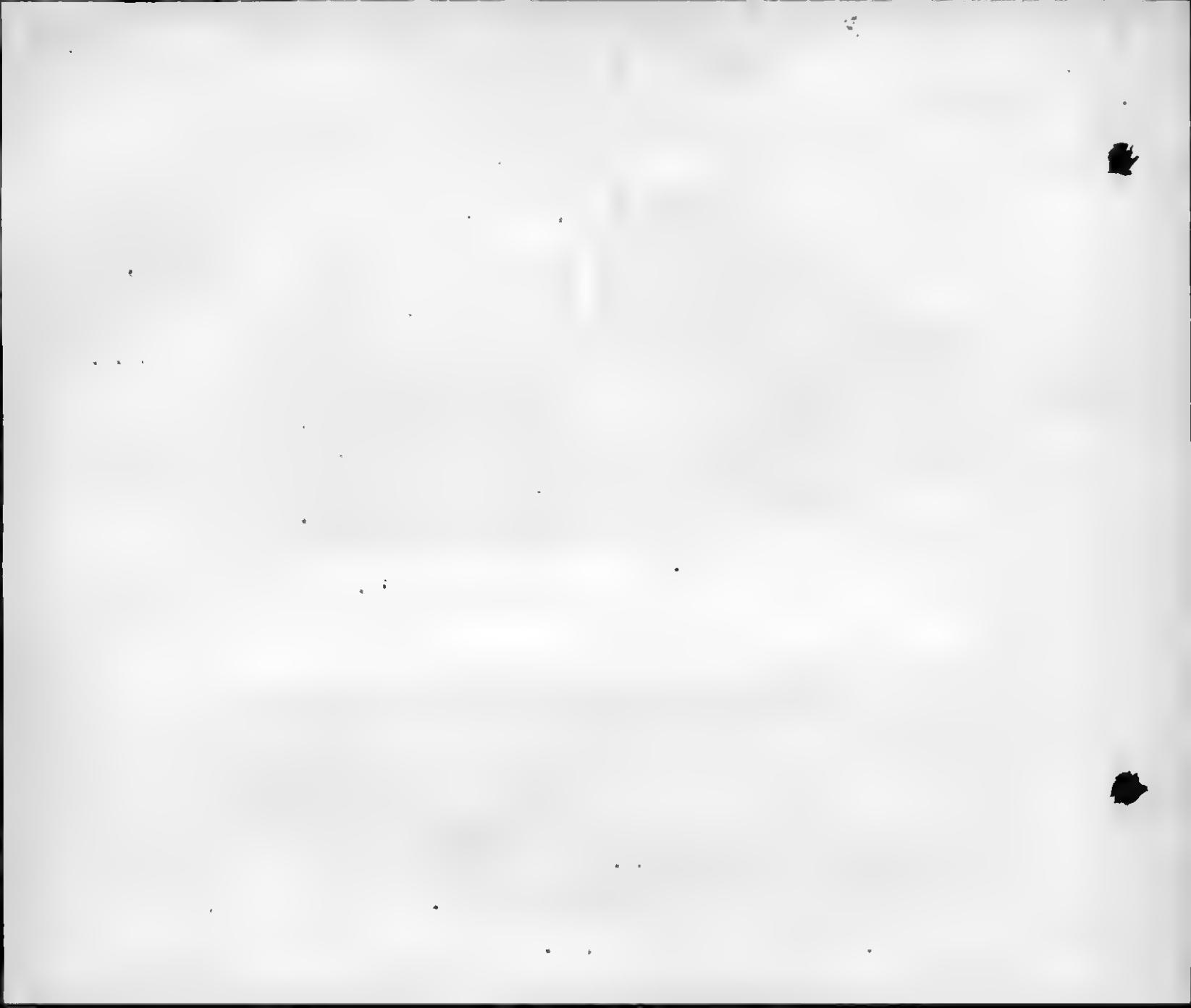
Reg. Dist. No.

05724

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Ohio		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adena		7-28	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Rural Delivery 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Jane	Last Carpenter	4. DATE OF DEATH May 23, 1959	Month May	Day 23	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 31, 1947	9. AGE (In years lost birthday) 11 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Andrew Carpenter				14. MOTHER'S MAIDEN NAME Nettie Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Severe Congestive Heart Failure following 7-4-7 DUE TO complete repair of Tetralogy of Fallot. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Severe Polycythemia secondary to Tetralogy of Fallot. (c) Subacute Bacterial Endocarditis.							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1959, to May 23, 1959, that I last saw the deceased alive on May 23, 1959, and that death occurred at 3:00 A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William P. Cornell, M.D. 5/23/59 PHYSICIAN'S NAME (Type) WILLIAM P. CORNELL, M.D.							
22a. BURIAL/CREMATION BURIAL (Specify)		22b. DATE THEREOF 5/26/59		22c. NAME OF CEMETERY OR CREMATORIUM New Alexandria Cem.		22d. LOCATION (City, town, or county) Alexandria, Ohio (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Md.				24a. REC'D BY REGISTRAR DATE MAY 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



X.1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.
M

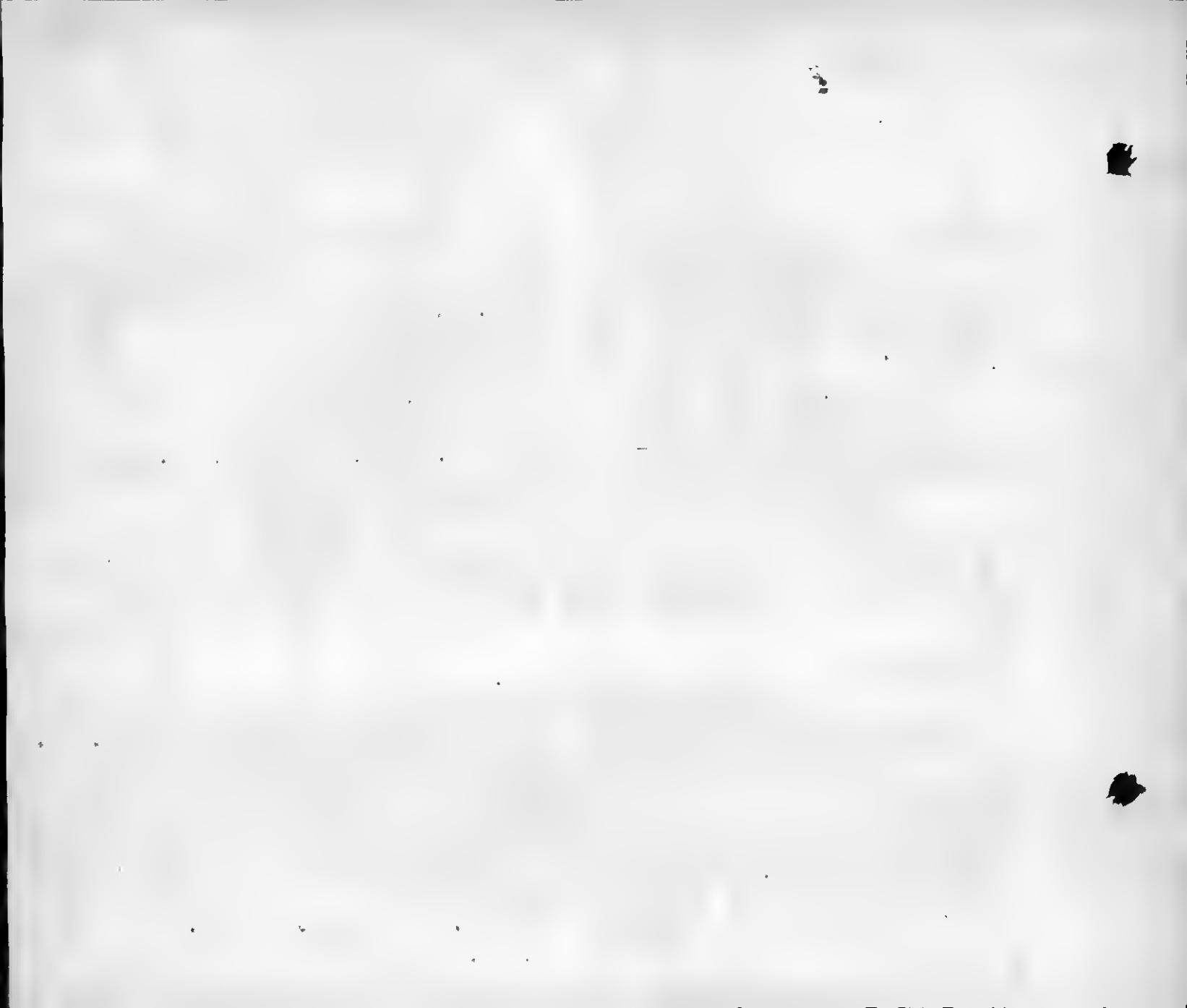
05725

Reg. Dist. No.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5748

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Monrovia		c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Monrovia		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Edna	Middle Pearl	Last Clay	4. DATE OF DEATH May 30	Month	Day	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1908	9. AGE (In years last birthday) 50 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop.		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Kong				14. MOTHER'S MAIDEN NAME Jessie Ridgley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-30-9974 17. INFORMANT Wilson E. Clay, Monrovia, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				INTERVAL BETWEEN ONSET AND DEATH Thoracic and cerebral hemorrhage			
181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)				Bullet wounds in left chest and base of left skull DUE TO (c)			
few minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Was shot by husband					
20c. TIME OF INJURY Hour 8:29 PM		20d. INJURY OCCURRED Month, Day, Year 5/30/59		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) RFD, Monrovia, Montg. Md.	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	EXAMINER'S NAME (Type) Frank J. Broschart			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 5/30/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1959		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Providence Meth. Damascus, Md.		22d. LOCATION (City, town, or county) Kempton, Md.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Moliswth</i>		24a. REC'D BY REGISTRAR DATE JUN 3 '59		24b. REGISTRAR'S SIGNATURE <i>Clifford S. Thomas</i>			
VS. A15ME BM 2/57							



X/1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

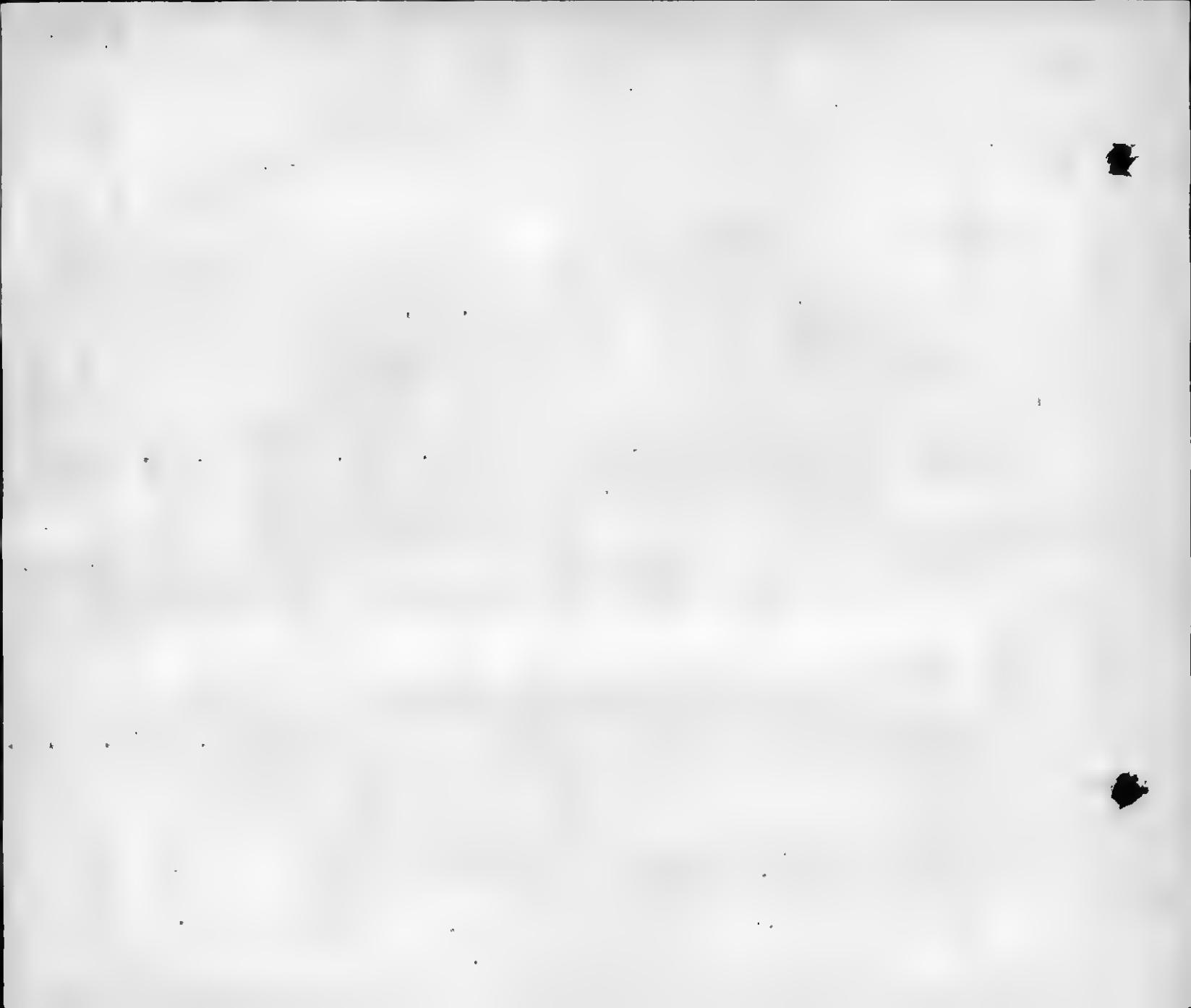
VS. A15ME
5M 2/57

5749 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Monrovia			c. LENGTH OF STAY IN 1b Years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS RFD Monrovia		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Wilson	Middle Carroll	Last Clay	4. DATE OF DEATH May 30
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1901	9. AGE (in years last birthday) 57 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Harry Clay		14. MOTHER'S MAIDEN NAME Ella Rhinehart		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 217-36-7843		17. INFORMANT Address Wilson E. Clay, Monrovia, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Bullet wounds in left chest and right skull (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Self inflicted bullet wounds			
20c. TIME OF INJURY Hour 8:30PM		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) RFD Monrovia, Montg. Co. Md.				(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED \$30/59	
EXAMINER'S NAME (Type) Frank J. Broschart					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Providence Meth.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Oliver L. McNaught</i>		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE JUN 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knapp	

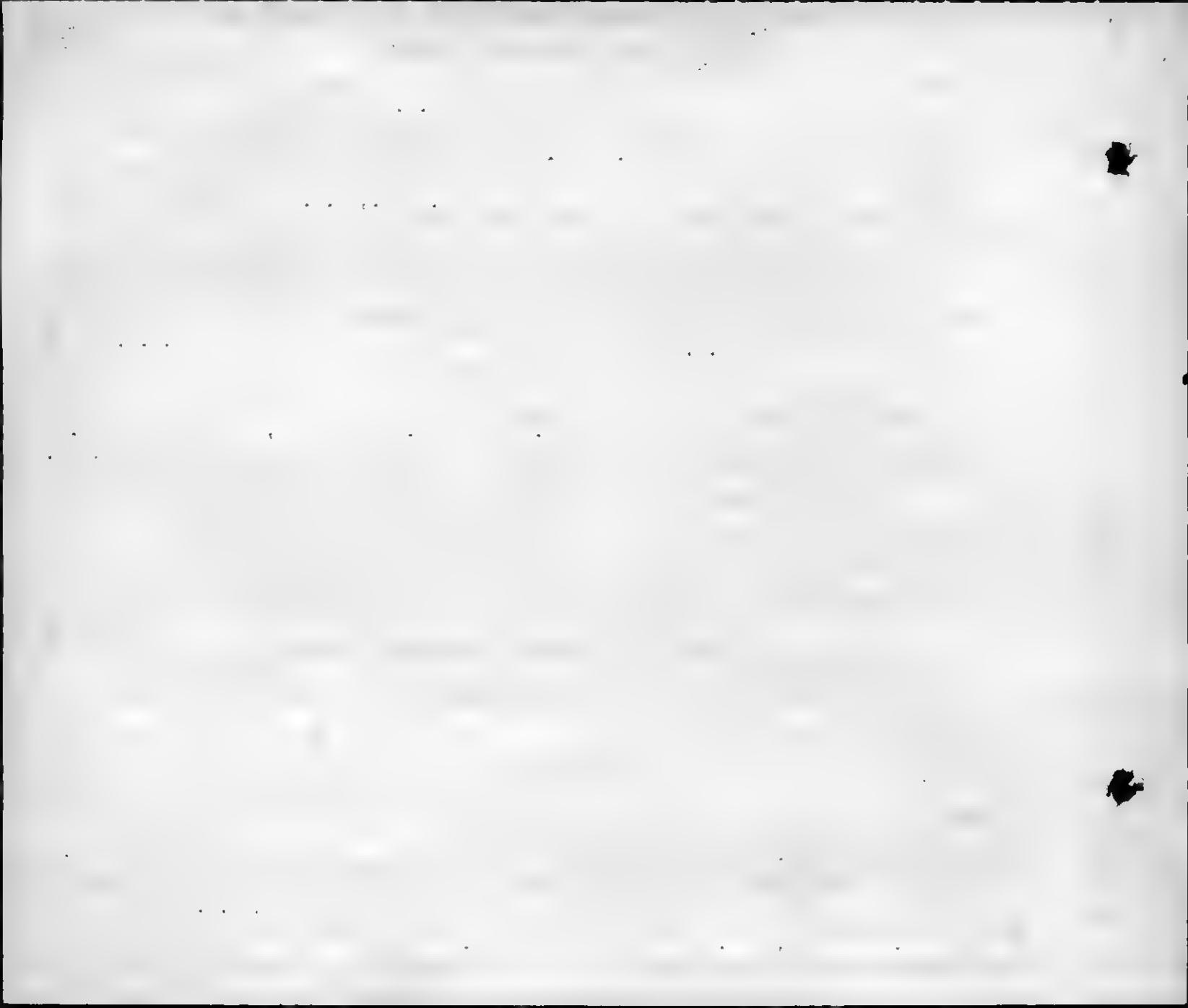


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5750 CERTIFICATE OF DEATH

Reg. Dist. No. 105727

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 yrs. 9 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAPLE LANE NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. STREET ADDRESS 644 MASS. AVE., N.E.		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Anna	Middle Elizabeth	Last CoBURN
4. DATE OF DEATH	Month MAY	Day 8	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/74
9. AGE (In years from last birthday) 84		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Engraving U.S. Government	
10c. BIRTHPLACE (State or foreign country) MARYLAND		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD FREE		14. MOTHER'S MAIDEN NAME ROSELLA GOODWIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Dorothy C. Carmichael		Address 8408 Houston St., Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
444X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if any. GENERALIZED ARTERIOSCLEROSIS			
DUE TO (b) ESSENTIAL HYPERTENSION			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) SENILITY	
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 14, 1956 to May 8, 1959 that I last saw the deceased alive on May 8, 1959 , and that death occurred at 1:15 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry M. Lowden		ADDRESS (Street, city or town, state) 5206 Norway Dr.	
PHYSICIAN'S NAME (Type) HENRY M. LOWDEN		DATE SIGNED 5/8/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/11/59	
22c. NAME OF CEMETERY OR CREMATORIUM GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		24a. REC'D BY REGISTRAR DATE MAY 15 1959	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05728

5751

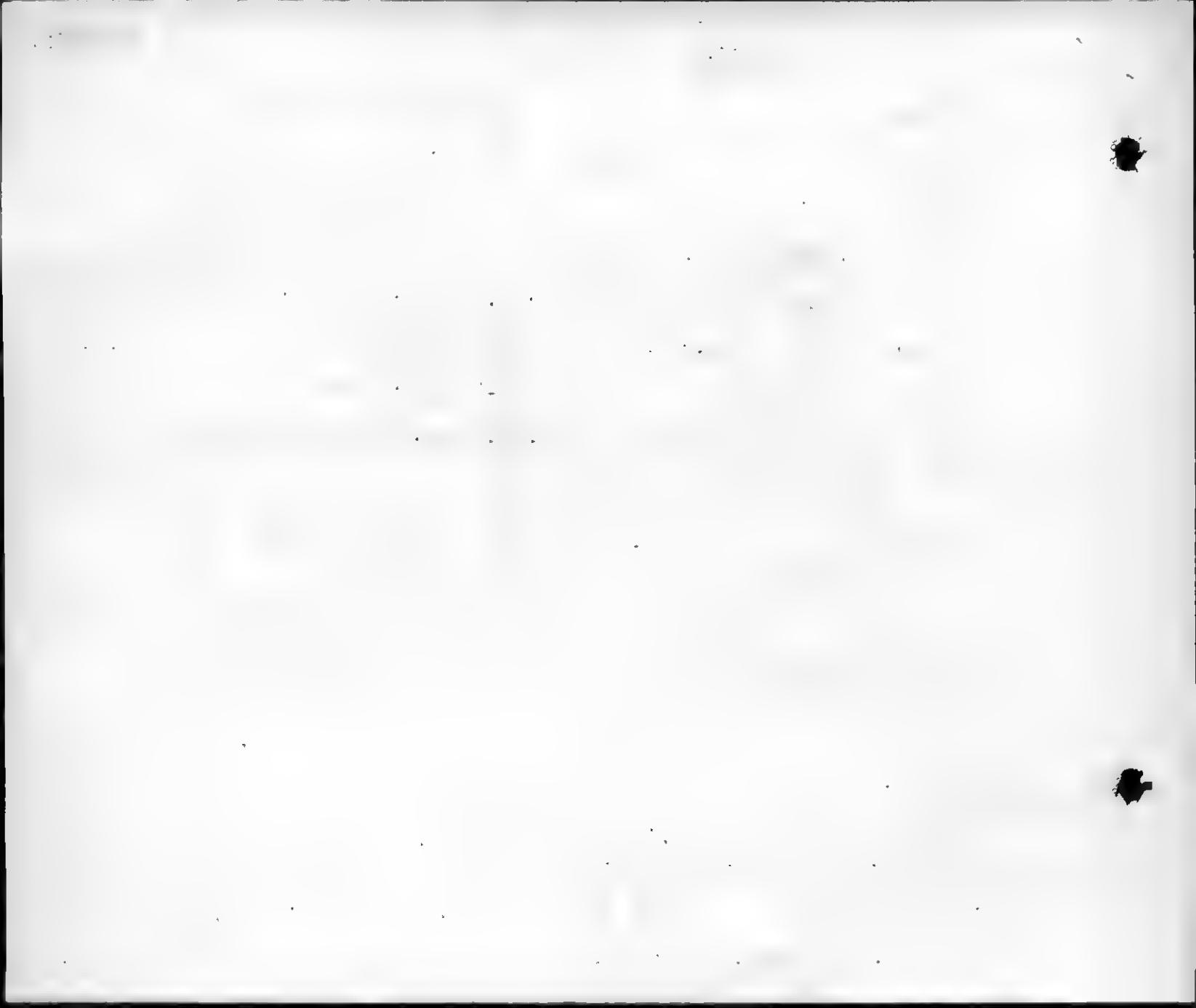
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 6 months		d. STREET ADDRESS 4344 East West Highway	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4344 East West Highway		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mildred	Middle A.	4. DATE OF DEATH May 29,
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wathan Marple		14. MOTHER'S MAIDEN NAME Elizabeth Dickinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dr. E. Russell Cook-Item #2-son		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) Pulmonary congestion; acute			
DUE TO 40s.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) arteriosclerotic heart disease			
DUE TO 20 yrs.			
(c)			
INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , 19, to 29 May , 19, that I last saw the deceased alive on 29 May , 19, and that death occurred at 4 1/2 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 7659 Old Georgetown Road Bethesda, Maryland			
DATE SIGNED 6/1/59			
ACTUAL SIGNATURE <i>John M. Wyman</i> M.D.			
PHYSICIAN'S NAME (Type) John M. Wyman, M. D.			
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/59	
22c. NAME OF CEMETERY OR CREMATORIUM XXXX Ivy Hill Cem.		22d. LOCATION (City, town, or county) (State) Alexandria, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 2 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

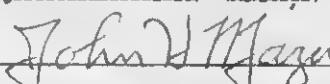
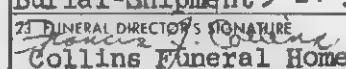


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5752 CERTIFICATE OF DEATH

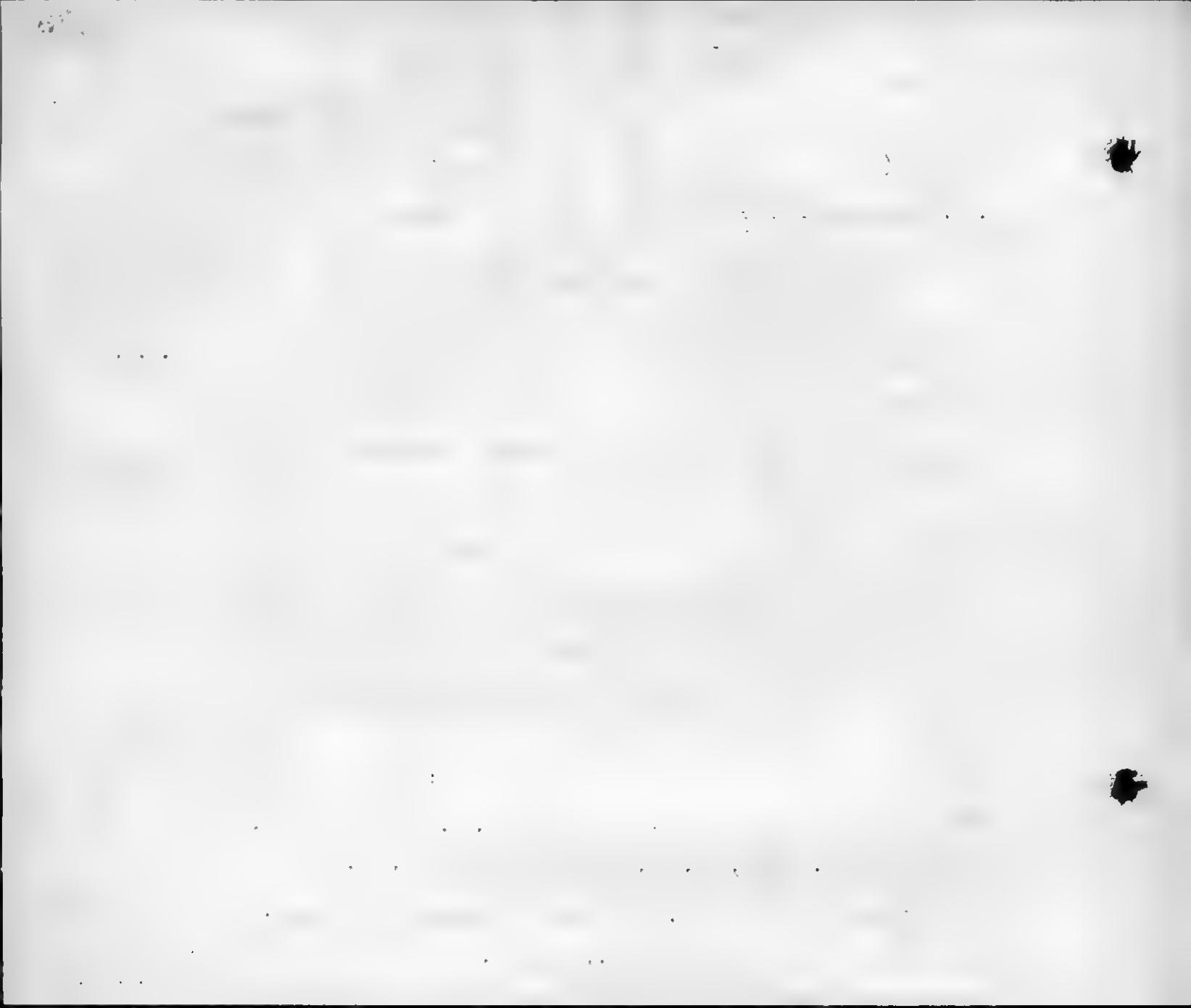
Reg. Dist. No. 215

05729

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Texas		b. COUNTY Kleberg		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville		d. STREET ADDRESS 1100 East Lott		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Cheryl	Middle Ann	Last COOLEY	4. DATE OF DEATH May 12 1959	Month May	Day 12	Year 1959
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-11-59		9. AGE (In years last birthday) yrs. 3 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Cooley				14. MOTHER'S MAIDEN NAME Geraldine Pedron				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Heart Block + Shock INTERVAL BETWEEN ONSET AND DEATH 1/2 hours Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) DUE TO Congenital Heart Disease Ventricular Septal Defect + Cocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OR CONTRIBUTING TO CAUSE OF DEATH (If either, notify medical examiner)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from April 25, 1959, to May 12, 1959, that I last saw the deceased alive on May 12, 1959, and that death occurred at 1:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) John H. Mazur, M.D., U. S. Naval Hospital, NNMC DATE SIGNED 5-13-59								
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) John H. MAZUR, LT, MC, USN Bethesda, Md.						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial-Shipment 5-14-59		22b. DATE THEREOF 5-14-59		22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's of the Assumption		22d. LOCATION (City, town, or county) Kulpmont (State) Pennsylvania		
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS 3821 14th St., NW, Wash. DC		24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

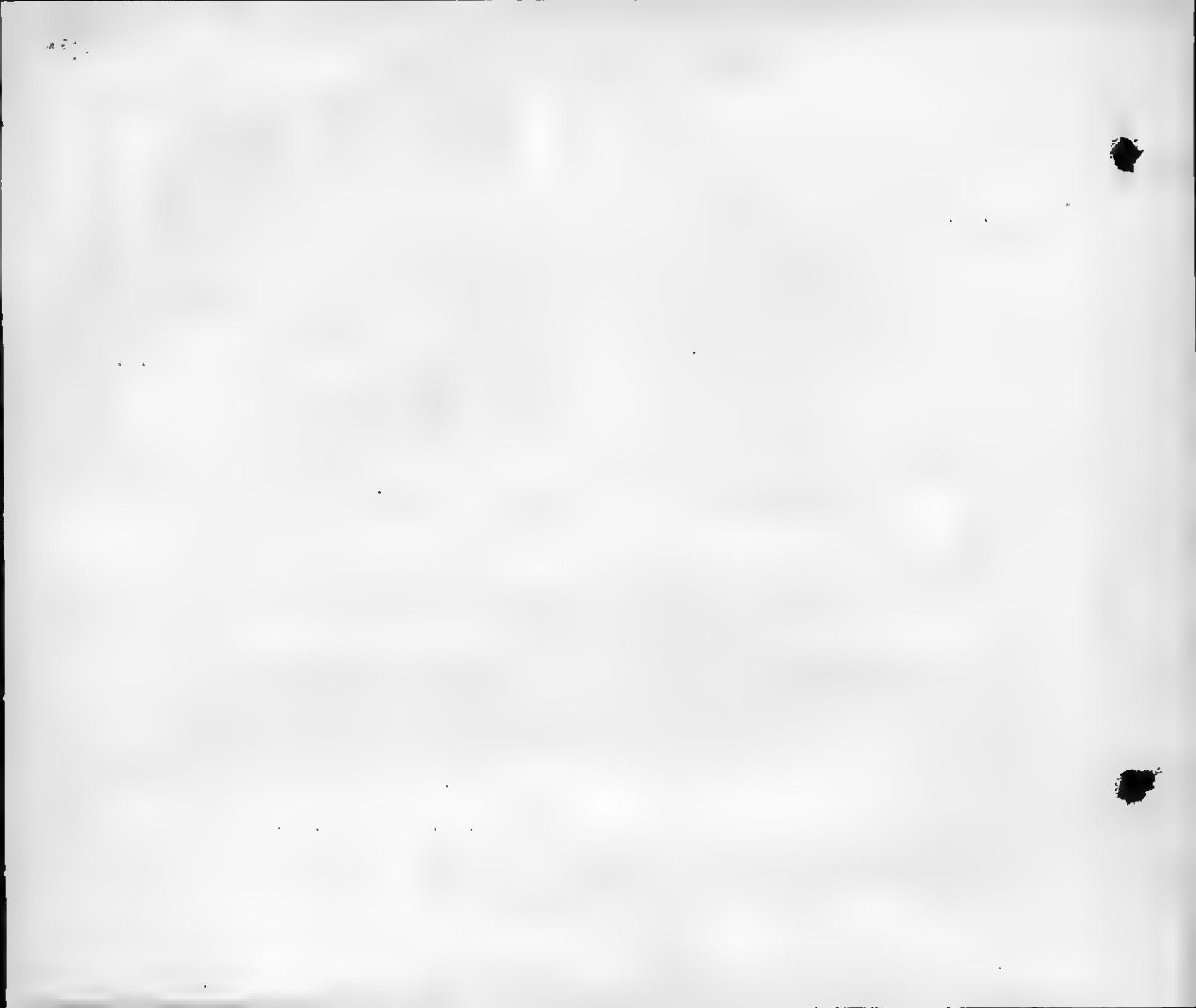
05730

5753 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY Arlington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		d. STREET ADDRESS 3112 S. Hayes Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William		First	Middle	Last	4. DATE OF DEATH CORLE	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH 5-3-59	9. AGE (In years lost birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph S. CORLE			14. MOTHER'S MAIDEN NAME Gloria Loraine REINHART					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia secondary to fetal atelectasis 762.0 DUE TO and hyaline disease. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from May 3, 1959, to May 5, 1959, that I last saw the deceased alive on May 4, 1959, and that death occurred at 3:05A M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. L. Walton</i> ADDRESS (Street, city or town, state) DATE SIGNED M.D. U. S. Naval Hospital 5-5-59								
PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MC, USN		Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-59		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR MAY 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5754

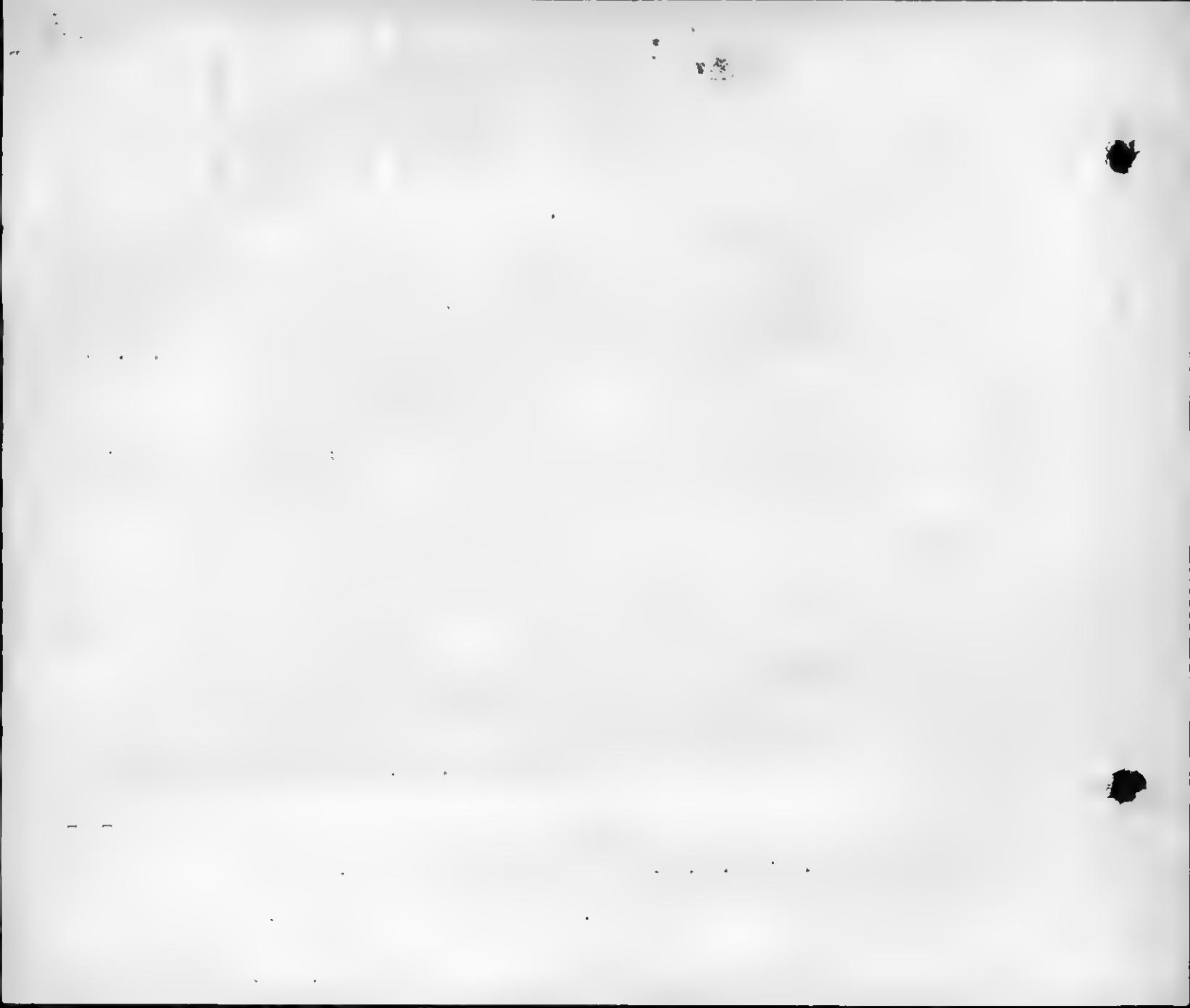
CERTIFICATE OF DEATH

Reg. Dist. No.

05731

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Kentucky</u>		b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>46 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Avawam</u>		d. STREET ADDRESS <u>(None)</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <u>Ira</u>	Middle <u>(None)</u>	Last <u>Cornett</u>	4. DATE OF DEATH May 18, 1959	Month May	Day 18	Year 1959				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1918</u>	9. AGE (In years last birthday) <u>40</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>0</u>	12. IF UNDER 24 HRS Hours <u>0</u>	13. FATHER'S NAME <u>James Cornett</u>	14. MOTHER'S MAIDEN NAME <u>Polly Hoskins</u>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO <u>WW II</u>	17. INFORMANT The Medical Record Address <u>The Clinical Center, Bethesda 14, Maryland</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>months</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <u>Hypertensive Vascular Disease</u>												
(c) DUE TO												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <u>April 2</u> , 1959, to <u>May 18</u> , 1959, that I last saw the deceased alive on <u>May 18</u> , 1959, and that death occurred at <u>7:05</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>								DATE SIGNED <u>5-19-59</u>				
ACTUAL SIGNATURE <u>John A. Oates, M.D.</u>		The Clinical Center National Institutes of Health Bethesda 14, Maryland										
PHYSICIAN'S NAME (Type) <u>John A. Oates, M. D.</u>												
22a. BURIAL/CREMATION, REMOVAL <u>CREMATION</u>		22b. DATE THEREOF <u>5-19th. 59</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Family Cemetery.</u>		22d. LOCATION (City, town, or county) <u>Hazard Ky.</u>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Demaine & Son.</u>		ADDRESS <u>Alexandria Va.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Kline</u>						

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Loge 4 may be retained by the hospital or attending physician.
2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05732

5755

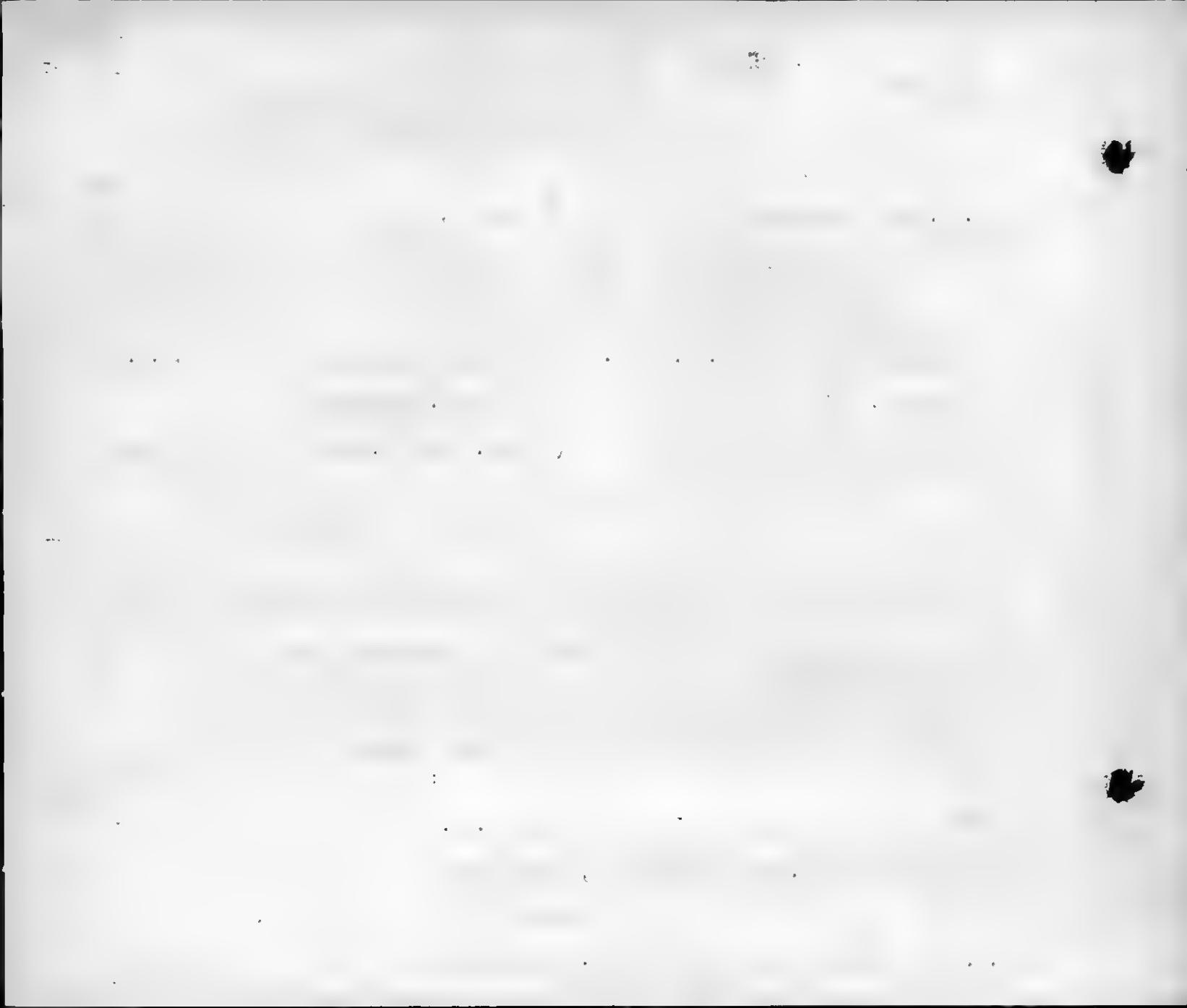
CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] o. STATE Virginia		b. COUNTY		
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Bethesda (Rural)		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Lorton				
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS RR #1, Box 70		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Howell		First Howell	Middle Gardner	Last CRIM	4. DATE OF DEATH May 11 1959	Month May	Day 11	Year 1959
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-98	9. AGE [In years last birthday] 60 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Chief Usher		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William S. Crim				14. MOTHER'S MAIDEN NAME Mary B. Hoffmaster				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Total no. or unknown) Yes		16. SOCIAL SECURITY NO WVI		17. INFORMANT None		Address (W) Mrs. Sadie M. Crim, same as #2 above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.				Pulmonary insufficiency		INTERVAL BETWEEN ONSET AND DEATH 10 yrs +		
(b) DUE TO Pulmonary fibrosis, etiol. undet.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY [Home, farm, factory, street, office bldg., etc.]		20f. (City or town) (County)		(State)
May 3, 1959		While at work <input type="checkbox"/> or work <input type="checkbox"/>		Bethesda		Maryland		MD
21. I certify that I attended the deceased from May 3, 1959, to May 11, 1959, that I last saw the deceased alive on May 9, 1959, and that death occurred at 5:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Joseph T. Horgan, M.D. U. S. Naval Hospital 5-11-59								
ACTUAL SIGNATURE Joseph T. Horgan		PHYSICIAN'S NAME (Type) Joseph T. HORGAN, LCDR, MC, USN Bethesda 14, Maryland						
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-59		22c. NAME OF CEMETERY OR CREMATORIAL Pohick Cemetery		22d. LOCATION (City, town, or county) Fairfax Co. (State) Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines Funeral Home, 2901 14th St. NW, Wash, DC		ADDRESS 14th St. NW, Wash, DC		24a. REC'D BY REGISTRAR MAY 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G243 6-2-59 et

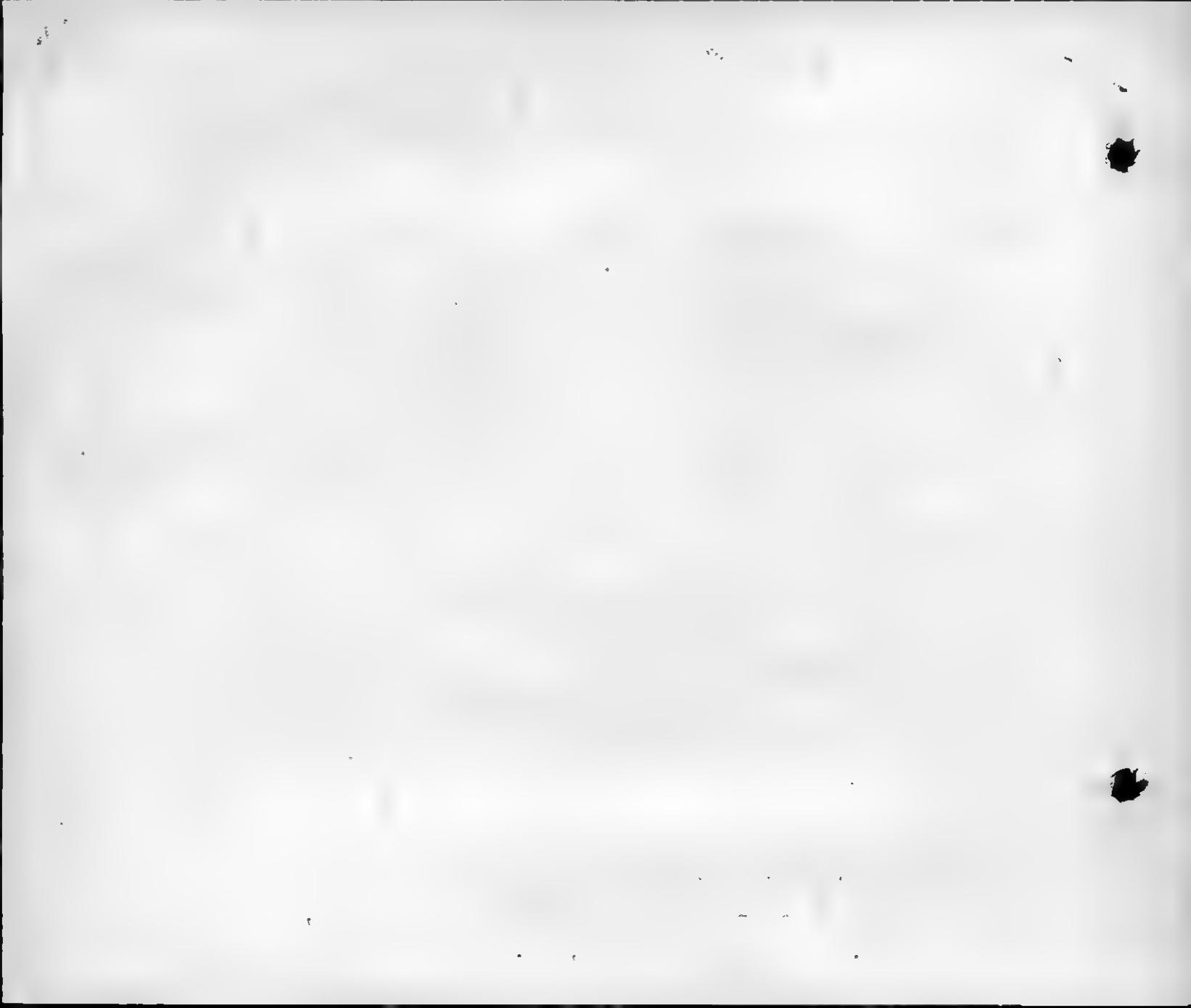
5756

CERTIFICATE OF DEATH

Reg. Dist. No.

05733

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDNOR		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDNOR		d. STREET ADDRESS Colesville Road, Rt. # 29							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BELMONT NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First BERTHA	Middle R.	Last CRUM	4. DATE OF DEATH	Month MAY	Day 23	Year 1959					
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/26/81	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor - Osteopathic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY USA							
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Gates		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yel. no. or unknown) NO		16. SOCIAL SECURITY NO. None							
17. INFORMANT BELMONT NURSING HOME RECORDS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) NEPHRITIS		Address EDNOR, MD.			INTERVAL BETWEEN ONSET AND DEATH 6 DAYS						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SENILITY		21. I certify that I attended the deceased from DECEMBER 1, 1959 to MAY 18, 1959 , that I last saw the deceased alive on MAY 18, 1959 , and that death occurred at 10:10 A.M. from the causes and on the date stated above.			20. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SANDY SPRING, MARYLAND	20f. (City or town) SANDY SPRING, MD.	(County) SANDY SPRING, MD.	(State) MARYLAND
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 5-25-59		22b. DATE THEREOF 5-25-59		22c. NAME OF CEMETERY OR CREMATORIUM Ames City Cemetery		22d. LOCATION (City, town, or county) Ames, Iowa							
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE MAY 27 '59		24b. REGISTRAR'S SIGNATURE Arthur & Kraus							



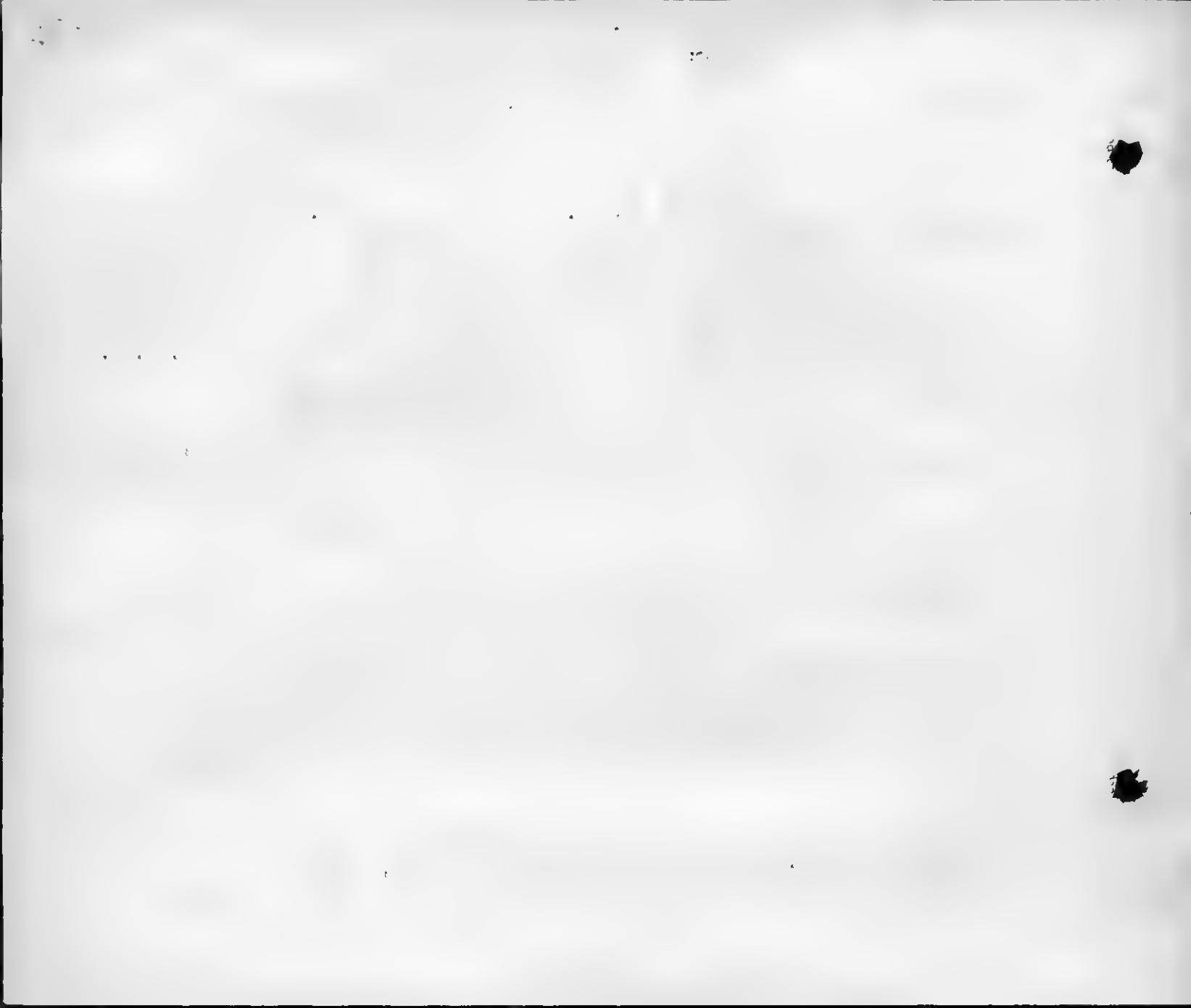
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5757 CERTIFICATE OF DEATH

05734

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 518 E Street, S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Gertrude	Middle (none)	Last Culver	4. DATE OF DEATH	Month May
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 7, 1886	9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		10c. BIRTHPLACE (State or foreign country) Holland	
13. FATHER'S NAME John Poll		14. MOTHER'S MAIDEN NAME Boukje van der Meulen		12. CITIZEN OF WHAT COUNTRY U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. b) DUE TO (c)		Necrotizing hepatitis etiology undetermined		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 24 , 1959, to May 5 , 1959, that I last saw the deceased alive on May 5 , 1959, and that death occurred at 2:15 P.M. from the causes and on the date stated above ACTUAL SIGNATURE <i>Howard M. Radwin, M.D.</i>				ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, Cremation or other Cremation		22b. DATE THEREOF 5-8-59		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem.	
22d. LOCATION (City, town, or county) Suitland, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lee's Sons Co.		ADDRESS 300-4th St. N.E.		24a. REC'D BY REGISTRAR DATE MAY 7 '59	
				24b. REGISTRAR'S SIGNATURE <i>Orthur L. Thomas</i>	



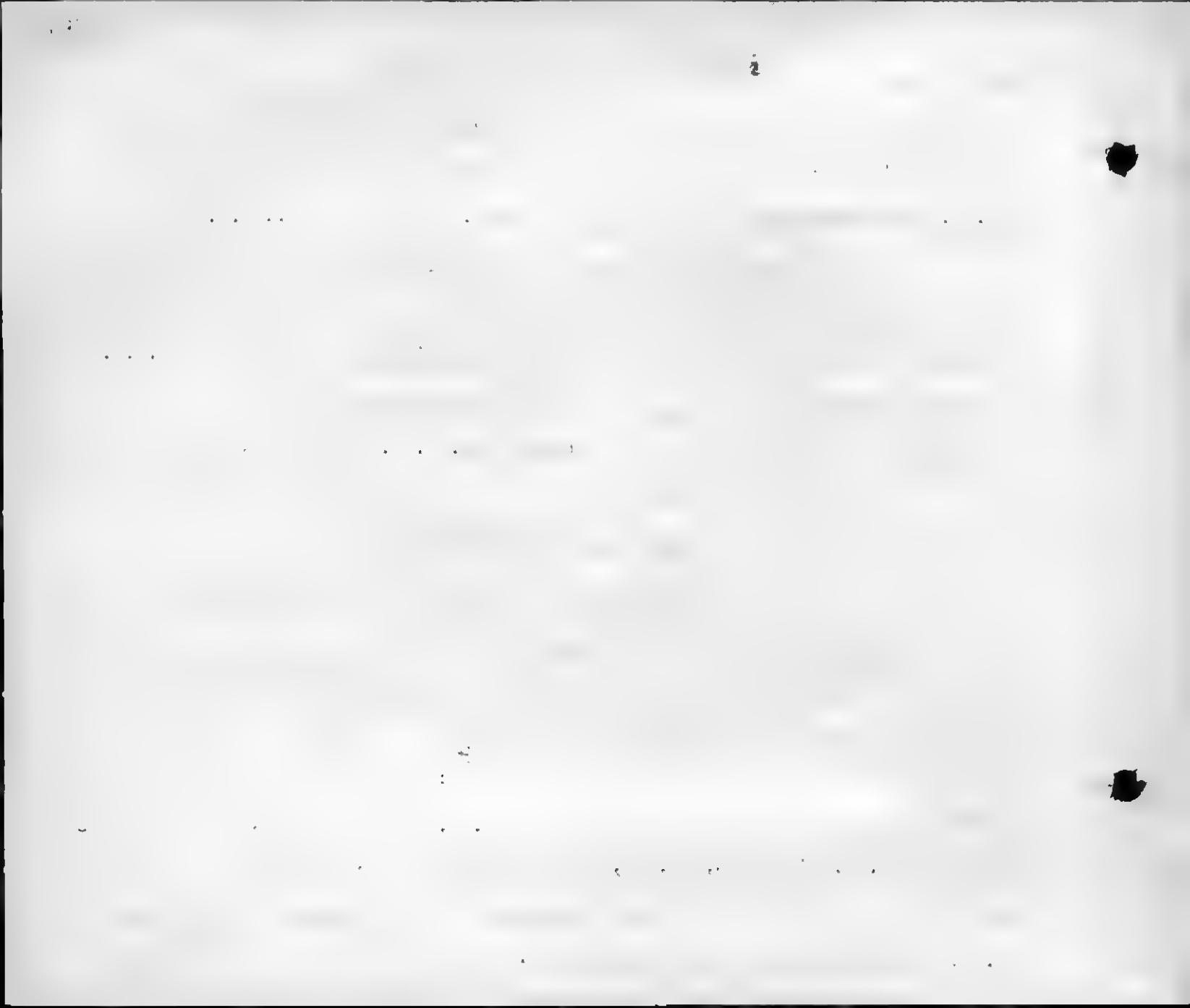
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05735

5758 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 161 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS Qtrs. "C", 2300 E St., N.W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Carolyn		First	Middle	Lost	4. DATE OF DEATH May	Month	Doy	Year
5. SEX Female		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 1-29-73	9 AGE (In years lost birthday) 86 yr	IF UNDER 1 YEAR Months		IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Theodore Haller		14. MOTHER'S MAIDEN NAME Elizabeth Poter						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (SisL) Adm. W. F. Boone, USN, same as #2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH		
DUE TO (c) Arteriosclerotic Heart Disease								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While or work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from December 2, 1959, to May 12, 1959, that I last saw the deceased alive on May 12, 1959, and that death occurred at 5:24 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>F. H. O'Connell</i>		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 5-13-59				
PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LT, MC, USN		22c. NAME OF CEMETERY OR CREMATORIUM Greenwood Cemetery		22d. LOCATION (City, town, or county) Shreveport			(State) Louisiana	
22b. BURIAL, CREMATION, OR REMOVAL (Specify) Burial Shipment 5-13-59		22d. LOCATION (City, town, or county) Shreveport		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan				
22e. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, Bethesda, Md.		ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		24c. REC'D BY REGISTRAR DATE MAY 14 '59				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05736

5712 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery Maryland		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Park		c. LENGTH OF STAY IN 1b 9 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS La Salle Road.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Sanatorium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
EMMA		Augusta	Dorothy
4. DATE OF DEATH		Month	Day
May 31		1959	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		White	B. DATE OF BIRTH Feb 13, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Shoemaker		14. MOTHER'S MAIDEN NAME Margaret Lehmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Dorothy B. Granados, 804 Remondelle T.D.M.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Congestive heart failure	
(b) DUE TO		Arteriosclerotic cardiovascular disease	
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 22</u> , 1959, to <u>May 31</u> , 1959, that I last saw the deceased alive on <u>May 31</u> , 1959, and that death occurred at <u>7:00 PM</u> from the causes and on the date stated above ACTUAL SIGNATURE <u>Harry N. Carlton</u> M.D. <u>940-254-5871 W. Walter May 31/59</u> ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3, 1959	22c. NAME OF CEMETERY OR CREMATORIUM London Park Cemetery
22d. LOCATION (City, town, or county) Baltimore, Maryland		22e. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Waites, 254 Carroll St NW 200</u>		24a. ADDRESS <u>J. Arthur Waites, 254 Carroll St NW 200</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thorne</u>
24c. REC'D BY REGISTRAR DATE JUN 2 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 fil. 24-36-17-35 et

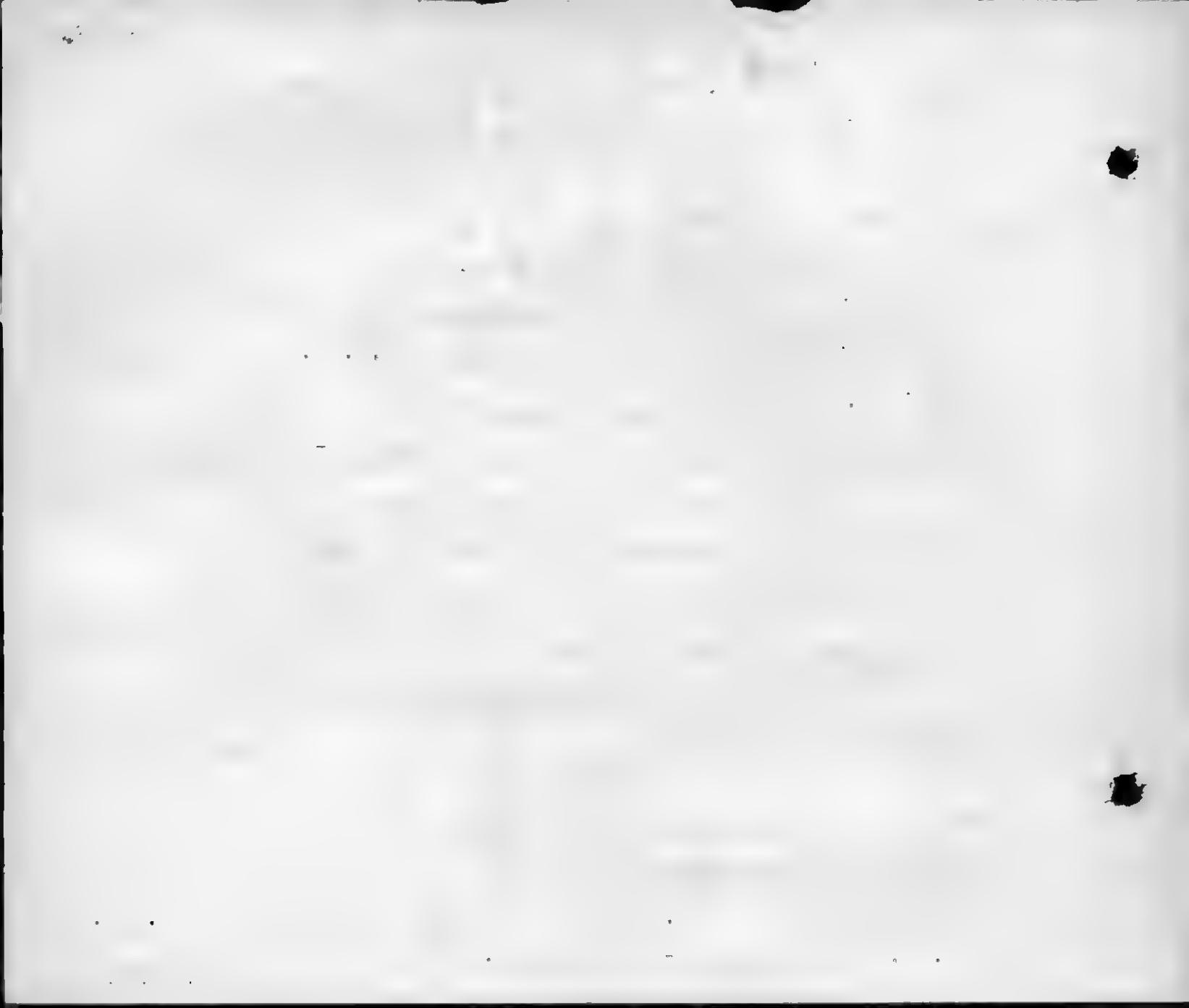
CERTIFICATE OF DEATH

05737

Reg. Dist. No.

575

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. COUNTY <i>Montgomery</i>	
d. LENGTH OF STAY IN 1b RURAL and give nearest town <i>Silver Spring</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D. C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSURANCE <i>Petrucci Gardens</i>		d. STREET ADDRESS <i>1717 Wyoming Ave. N.W.</i>	
e. FIRST NAME MIDDLE NAME Last Name <i>Henrietta A. Darneille</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. SEX <i>F</i>		g. DATE OF DEATH <i>May 5 1959</i>	
h. COLOR OR RACE <i>W</i>		i. B. DATE OF BIRTH <i>May 10-1877 82 yrs.</i>	
j. 10a. USUAL OCCUPATION (Give kind of work done during time of working life, even if retired) <i>clerk (Govt.)</i>		j. 10b. KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>	
j. 10c. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>		j. 10d. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
k. 13. FATHER'S NAME <i>Benjamin J. Darneille</i>		l. 14. MOTHER'S MAIDEN NAME <i>Henrietta Addison</i>	
m. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		n. 16. SOCIAL SECURITY NO. <i>no</i>	
o. 17. NEIGHBOR <i>Nursing</i>		p. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) <i>Cerebral Atherosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>one day</i>	
q. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		q. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
q. 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>May 10 1959</i>		q. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
q. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		q. 20f. (City or town) (County) (State)	
q. 21. I certify that I attended the deceased from <i>Nov. 10, 1958</i> to <i>May 5, 1959</i> that I last saw the deceased alive on <i>May 4, 1959</i> , and that death occurred at <i>550</i> M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>M. B. Hilderman</i> M.D. ADDRESS (Street, city or town, state) <i>304-657 Silver Spring</i> DATE SIGNED PHYSICIAN'S NAME (Type) <i>R. B. Hilderman</i>			
q. 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		q. 22b. DATE THEREOF <i>5/5/59</i>	
q. 22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Crematory</i>		q. 22d. LOCATION (City, town, or county) (State) <i>Prince Georges Co. Md.</i>	
q. 23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Company -Washington, D.C.</i>		q. 24a. REC'D BY REGISTRAR DATE <i>MAY 6 '59</i>	
q. 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

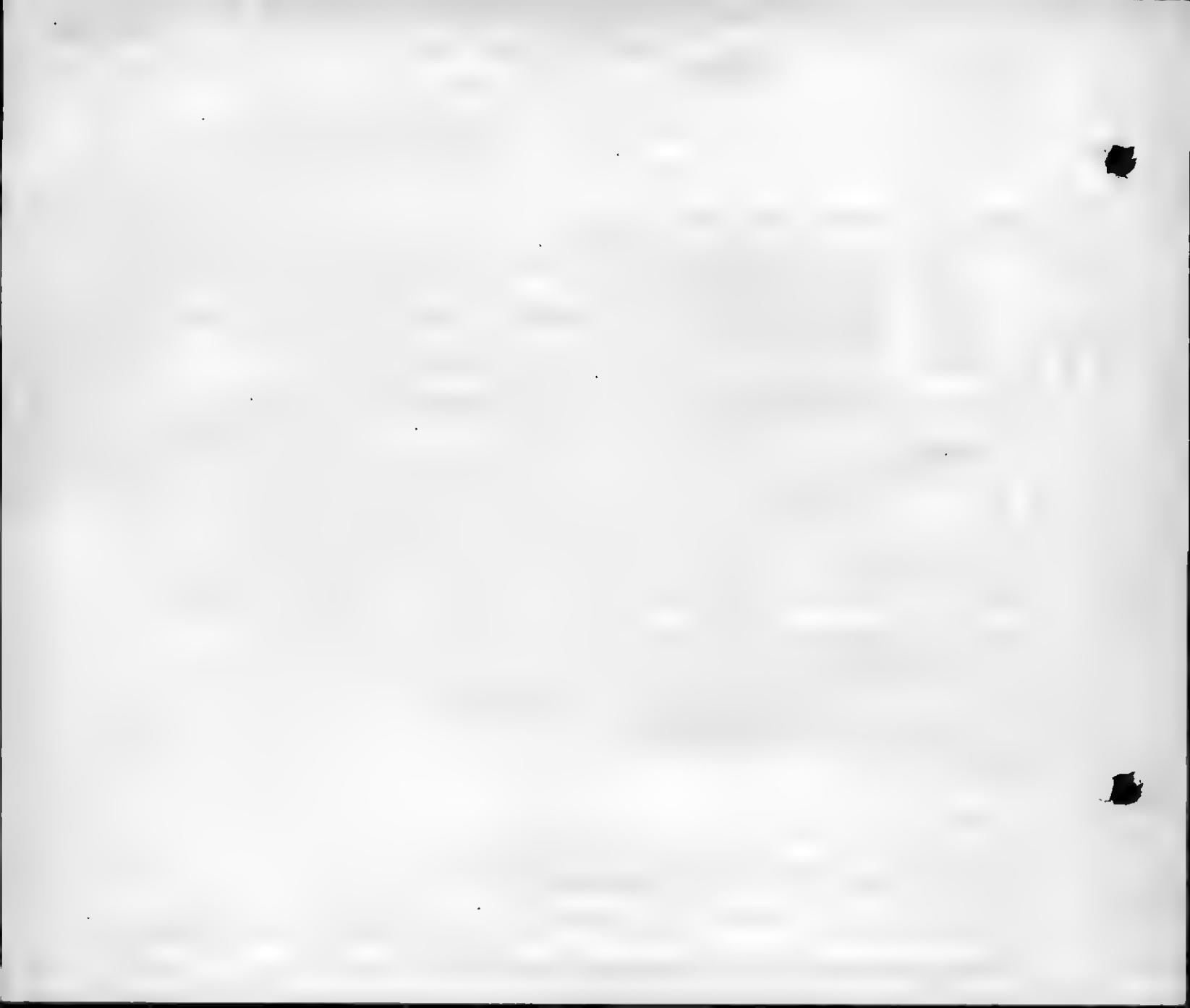


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

05738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		5768 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>4 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Mar Park</i>		d. STREET ADDRESS <i>15212 Augusta St.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Manor Hos.</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Ernest</i>		First <i>E.</i>	Middle <i>L.</i>	Last <i>Kellinger</i>	4. DATE OF DEATH <i>May 22 1959</i>	Month <i>May</i>	Day <i>22</i>	Year <i>1959</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 6, 1883</i>		9. AGE (In years last birthday) <i>76 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>76</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Grocer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Grocer</i>		11. BIRTHPLACE (State or foreign country) <i>Frost Royal, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George W. Kellinger</i>		14. MOTHER'S MAIDEN NAME <i>Alvaretta Rogers</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>780-78-1234</i>		17. INFORMANT <i>McElynn D. Beall</i>		Address <i>2121 Augusta St., Glen Mar Park, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>446X</i>		DUE TO <i>Anemia, terminal</i>				<i>1 week</i>		
Conditions, if any, which gave rise to Immediate cause (a), stating the under- lying cause last. <i>hypertension, advanced</i>		(b) <i>hypertension, advanced</i>				<i>1 yr</i>		
		DUE TO <i>Cerebro-sclerosis, general, severe</i>				<i>10 yrs +</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral thromboses, multiple</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>3921 Tregeman St.</i>	(County) <i>Wash 15 DC</i>	
21. I certify that I attended the deceased from alive on <i>May 21, 1959</i> , and that death occurred at <i>1145 P.M.</i> from the causes and on the date stated above.						DATE SIGNED <i>5/23/59</i>		
ACTUAL SIGNATURE <i>Stewart Clapp</i>						ADDRESS (Street, city or town, state) <i>3921 Tregeman St., Wash 15 DC</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/25/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Kellinger Cem.</i>		22d. LOCATION (City, town, or county) <i>Walterick</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Cherry Chase Funeral Home, Wash DC</i>		ADDRESS <i>809 Wisconsin Ave</i>		24a. REC'D BY REGISTRAR <i>John S. Moore</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Moore</i>		
				DATE <i>MAY 26 '59</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05739

5761 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		b. COUNTY <u>Stevens</u>				
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewelah</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9612 Glencrest Lane</u>		d. STREET ADDRESS <u>111 W. Colville Ave</u>				
3. NAME OF DECEASED (Type or print) <u>Della</u>		First <u>E</u>	Middle <u>Dan</u>			
4. DATE OF DEATH <u>May 29</u>		Month <u>May</u>	Day <u>29</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>12/10/78</u>		9. AGE (In years from birthday) <u>80</u>				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				
11. BIRTHPLACE (State or foreign country) <u>Montana</u>		12. CITIZEN OF WHAT COUNTRY? <u>C.I.S.</u>				
13. FATHER'S NAME <u>John Henry Evans</u>		14. MOTHER'S MAIDEN NAME <u>Clara Peters.</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or ground/ship) <u>No</u>		16. SOCIAL SECURITY NO. <u>333-05-08970</u>				
17. INFORMANT <u>Helen Peters</u>		Address <u>9612 Glencrest Lane</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH <u>Cerebral thrombosis</u> <u>Generalized arteriosclerosis</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>None</u>				
20c. TIME OF INJURY Hour o. m. p. m.	Month <u>May</u>	Day <u>19</u>	Year <u>1959</u>			
20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>—</u>	(County) <u>—</u>	(State) <u>—</u>	
21. I certify that I attended the deceased from <u>May 12, 1959</u> to <u>present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 25, 1959</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>John B. Umhau</u> M.D. ADDRESS (Street, city or town, state) <u>8805 Conn Ave</u> DATE SIGNED <u>5/29/59</u>						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-1-59</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u>	(State) <u>—</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

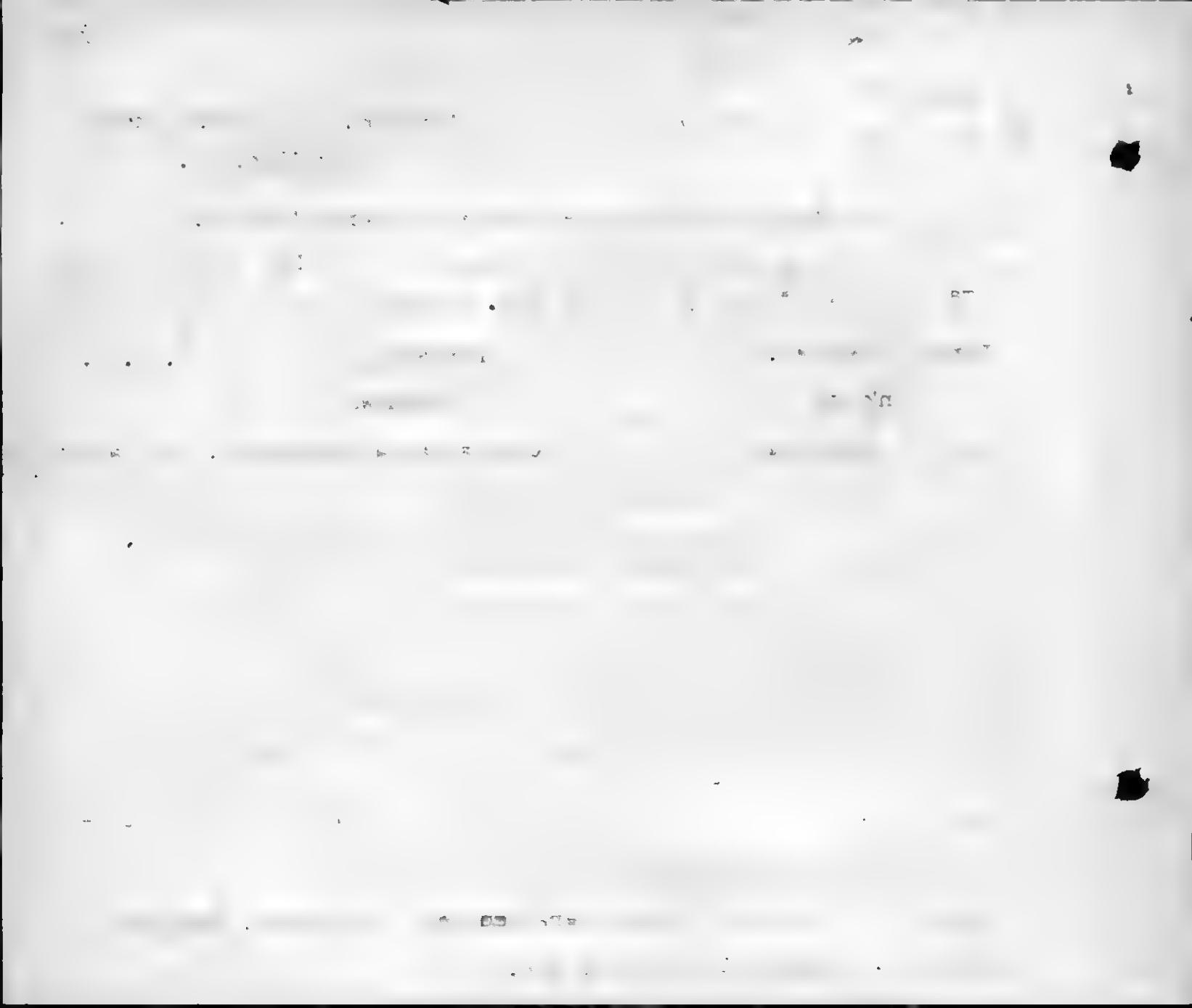
5762 CERTIFICATE OF DEATH

05740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS Route 32 Clarksville, Md.	
3. NAME OF DECEASED (Type or print) Christian		First Eichen	Middle
3. NAME OF DECEASED (Type or print) Christian	4. DATE OF DEATH May 8 1959	5. SEX Male	6. COLOR OR RACE White
	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1895	9. AGE (In years last birthday) 63 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber (self em.)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Hungary	12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown	Address Victoria Maria Neduhal Rt. 32 Clarksville	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) World War II	17. INFORMANT
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) / / X DUE TO Cachexia		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Adenocarcinoma of the stomach with 7 abdominal metastases		2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 10 1958 to May 8 1959 , that I last saw the deceased alive on May 8 1959 , and that death occurred at 5:15 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED 5-8-59			
ACTUAL SIGNATURE <i>Charles S. Whitaker</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5/12/59 22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery 22d. LOCATION (City, town, or county) Baltimore, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Ave.	ADDRESS 	24a. REC'D BY REGISTRAR 	24b. REGISTRAR'S SIGNATURE Arthur L. Keane

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for reference.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for reference.

VS ATSM
EM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5763 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05741
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>DC</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Yorktown Village 1 hr. 15 min</i>		c. LENGTH OF STAY IN 1b <i>5104 Washington Dr. Wash. D.C.</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>First</i>		e. STREET ADDRESS <i>1756 Penna. Ave. N.W.</i>									
3. NAME OF DECEASED (Type or print) <i>Taive Linnea Erickson</i>		f. DATE OF DEATH <i>May 1 1959</i>									
4. SEX <i>Male</i>		5. COLOR OR RACE <i>White</i>									
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <i>Widowed</i>		7. DATE OF BIRTH <i>11-27-1899</i>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Security Office</i>									
10c. BIRTHPLACE (State or foreign country) <i>Mich</i>		11. AGE (In years last birthday) <i>59 yrs.</i>									
13. FATHER'S NAME <i>John Erickson</i>		14. MOTHER'S MAIDEN NAME <i>Warkason</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>?</i>		16. SOCIAL SECURITY NO. <i>?</i>									
17. INFORMANT <i>Curie Erickson (wife)</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										DATE SIGNED <i>5-1-59</i>	
ACTUAL SIGNATURE <i>Frank J. Borschart</i>		EXAMINER'S NAME (Type) <i>FRANK J. Borschart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <i>54816</i>		22b. DATE THEREOF <i>5/4/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>THA'L. MEMORIAL PARK</i>		22d. LOCATION (City, town, or county) <i>Fairfax County</i>		(State) <i>Vd.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Shaw's Sons Inc.</i>		ADDRESS <i>1756 Penna. Ave. N.W.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kline</i>		24b. REGISTRAR'S SIGNATURE <i>MAY 5 '59</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

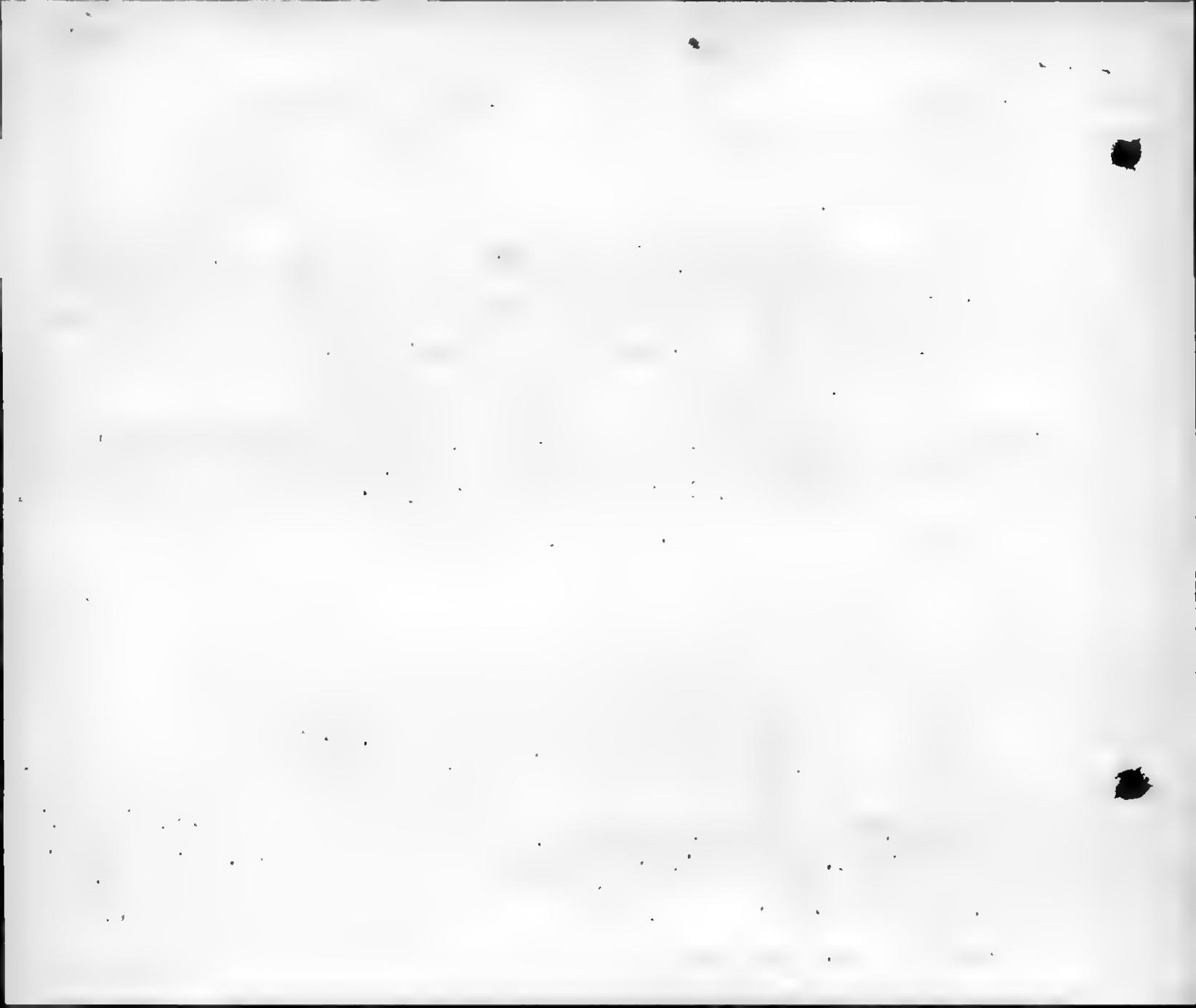
5764 CERTIFICATE OF DEATH

Reg. Dist. No.

105742

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland, Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4901 Rugby Avenue		e. STREET ADDRESS 4901 Rugby Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SADIE		First	Middle	Last	4. DATE OF DEATH May 21, 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1879	9. AGE (In years last birthday) 79	10. IF UNDER 1 YEAR Months 10 Days 3 Hours 5 Min.
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Brooklyn, N. Y.	
13. FATHER'S NAME Unknown (Maneely)		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes		INFORMANT Curtis S. Feeser - Item #2-husband	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 231X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DUE TO (c)		Cerebrovascular accident Cerebral arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH 50 minutes ?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>alive on May 20, 1959</u> and that death occurred at <u>9:35 A.M.</u> on the date stated above.		Nov. 1, 1952 to May 21, 1959		ADDRESS (Street, city or town, state) 104 Chevy Chase Drive, Chevy Chase 15, Md.	
ACTUAL SIGNATURE <i>George A. GRAY, M.D.</i>		M.D.		DATE SIGNED 5/21/59	
PHYSICIAN'S NAME (Type) George A. GRAY, M.D.		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		22d. LOCATION (City, town, or county) Prince George Co., Md. (State)	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-59		24a. REC'D BY REGISTRAR MAY 25 '59	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

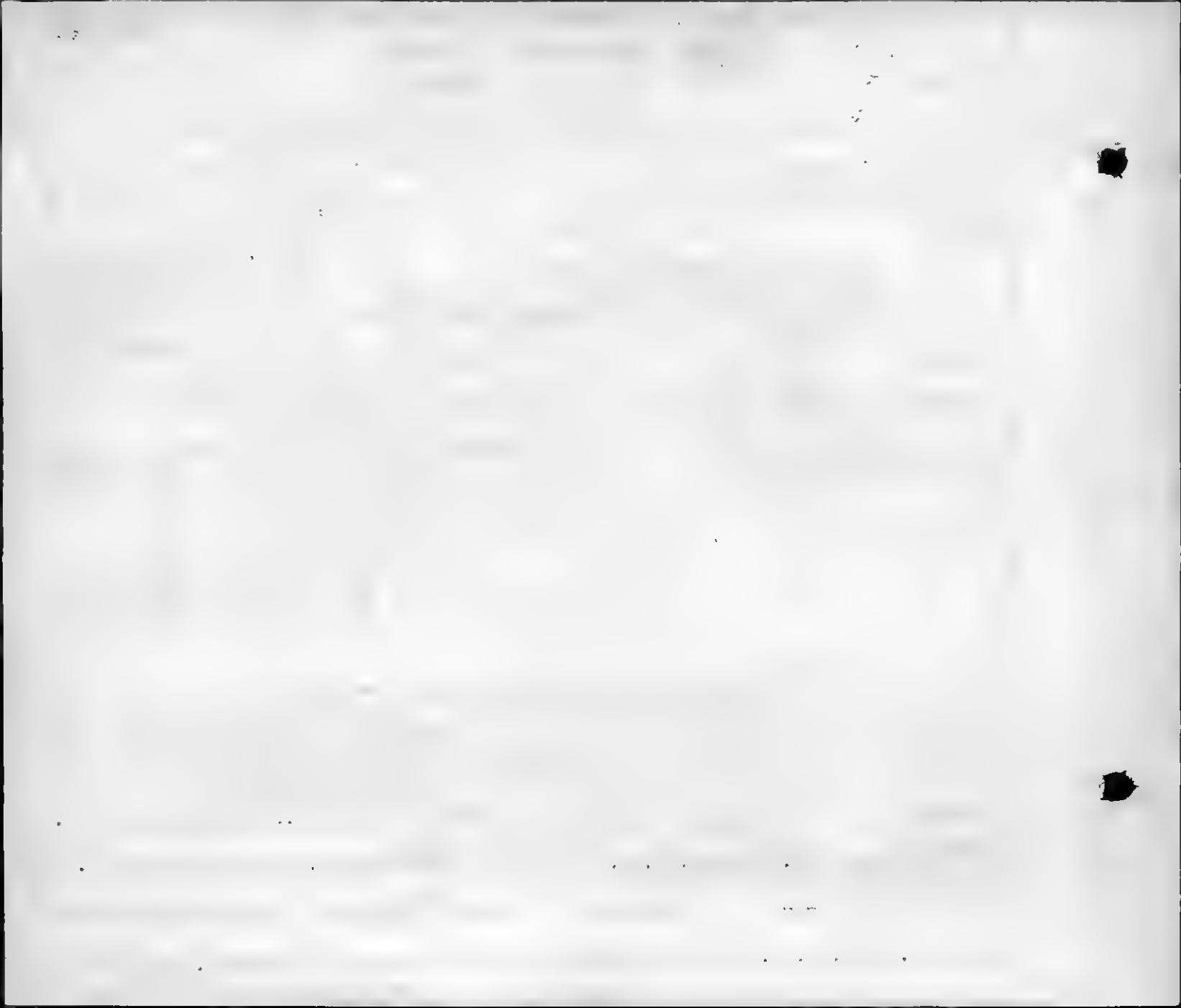
05743

5713 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,		161					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		d. STREET ADDRESS 7423 Aspen Court,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month	Day	Year				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.					
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 5, 1959	6	6 55					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? America					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Richard Lee Fenn		Joan Rebecca Wittenman									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no				father							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Infection</i>											
DUE TO <i>Respiratory Infection</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Pneumonia</i>											
DUE TO <i>Pneumonia</i>											
C. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)								DATE SIGNED			
ACTUAL SIGNATURE <i>Winston E. Cochran</i>		M.D.		927 Pershing Dr., Silver Spring, Md.							
PHYSICIAN'S NAME (Type) <i>Winston E. Cochran, M. D.</i>		927 Pershing Dr., Silver Spring, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5-5-59		22c. NAME OF CEMETERY OR CREMATORIAL Washington Sanitarium and Hospital		22d. LOCATION (City, town, or county) Takoma Park, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington Sanitarium and Hospital, Takoma Park, Maryland		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur & Fife					
20, May 1959				DATE MAY 7 '59							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 1 may be reprinted by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

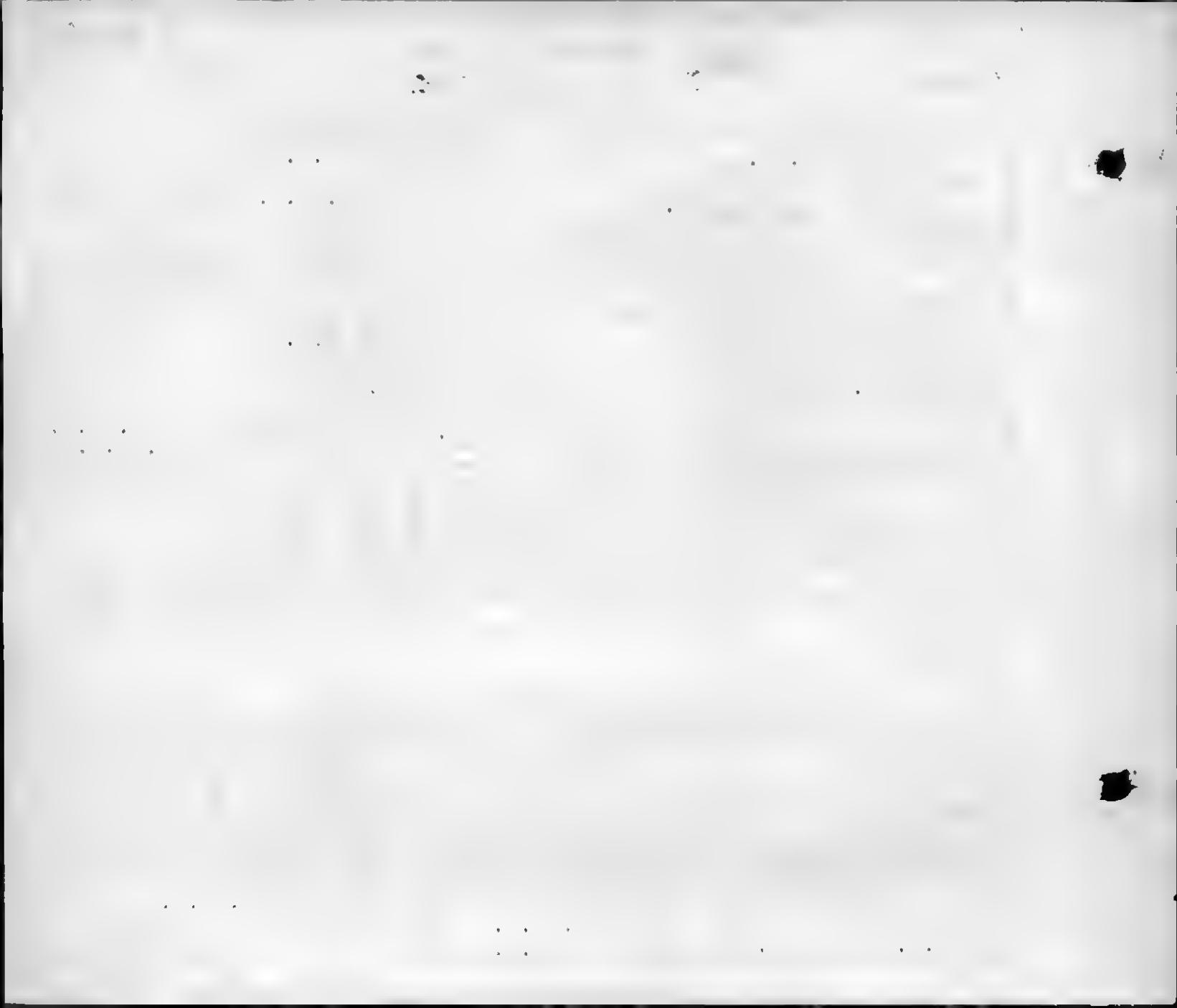
5714

CERTIFICATE OF DEATH

05744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fair Hill Rest. Home 207 Hudson Ave.				d. STREET ADDRESS 3900 14th St. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Sarah	Middle Jane	Last Fischer	4. DATE OF DEATH May	Month Day Year 1 19 59
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/19/82	9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME William H. Forrest		14. MOTHER'S MAIDEN NAME Carrie M. Sauers		12. CITIZEN OF WHAT COUNTRY? Address 2714 31st St. S.E. Washington, D.C.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO		17. INFORMANT George A. Fischer	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first 180X		Cerebrovascular Accident		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
(b) DUE TO Generalized Arterosclerosis					
(c) Dyslipidemia with hypertension				1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 2:30 p. m.		Month 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Takoma Park	(City or town) (County) (State) Maryland
21. I certify that I attended the deceased from <u>January</u> , 1959, to <u>April 30th</u> , 1959, that I last saw the deceased alive on <u>April 30</u> , 1959, and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. 8700 Calverton Rd Silver Spring, Maryland 20901	
ACTUAL SIGNATURE Lyle Williams				DATE SIGNED May 4, 1959	
PHYSICIAN'S NAME (Type) Lyle Williams, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/4/59	22c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery	22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.		2901 14th St. N.W.	24a. REC'D BY REGISTRAR DATE MAY 4 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5765 CERTIFICATE OF DEATH

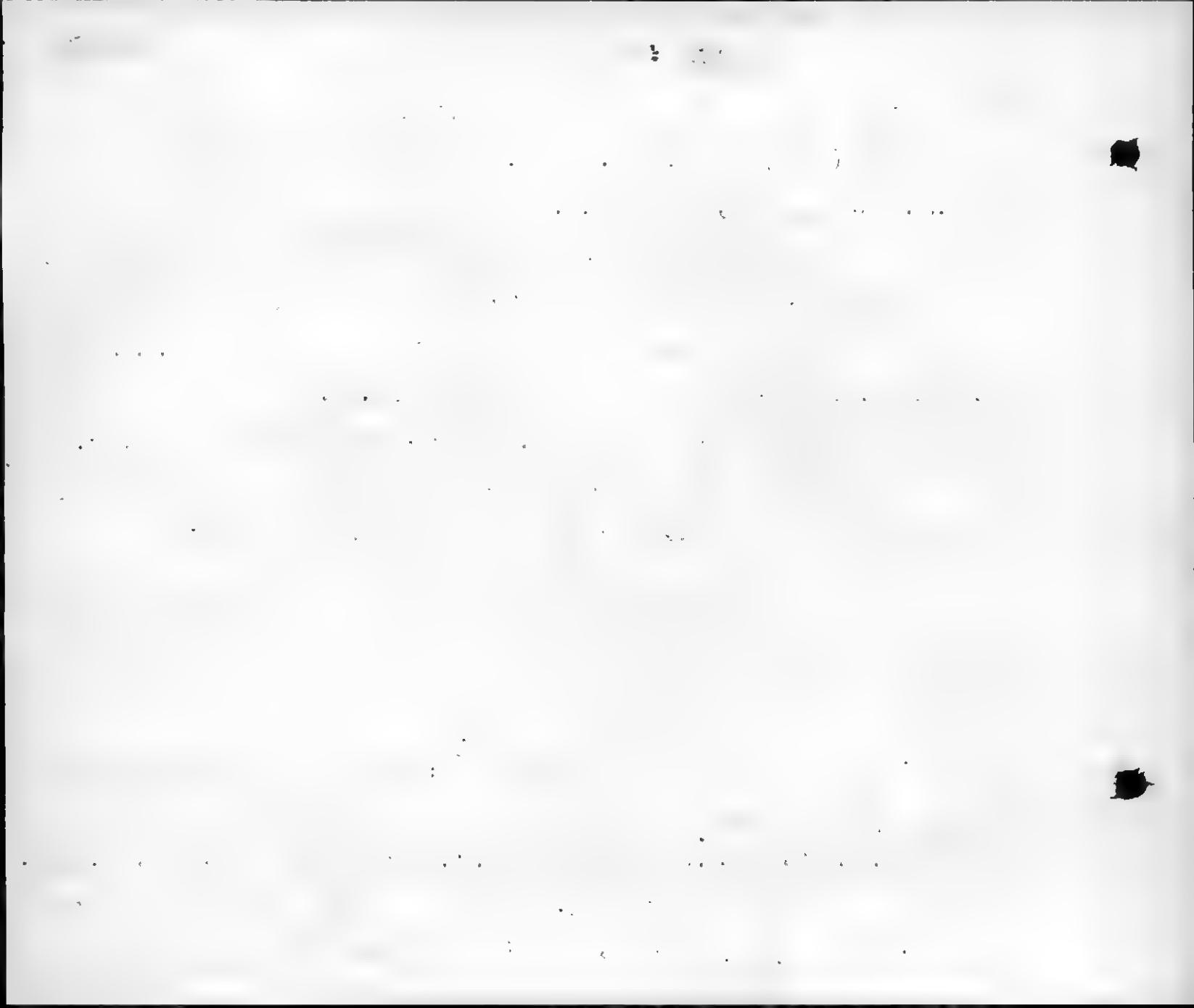
Reg. Dist. No.

05746

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia		b. COUNTY Loudoun	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 16 19 hrs. 50 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hamilton		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Chester	Middle Lawrence	Last Fordney	4. DATE OF DEATH	Month May	Day 26	Year 19 59
S. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1892	9. AGE (in years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USMC		10b. KIND OF BUSINESS OR INDUSTRY USMC		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Warren Fordney				14. MOTHER'S MAIDEN NAME Kathryn Haaren			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) Yes		16. SOCIAL SECURITY NO. WW-1 & WW-2		INFORMANT Mrs. Dorothy Fordney (Wife)		Address Hamilton, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) cerebral hemorrhage Hypertensive cardiovascular disease ? INTERVAL BETWEEN ONSET AND DEATH 20 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 25, 19 59 to May 26, 19 59, that I last saw the deceased alive on May 26, 19 59, and that death occurred at 6:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>F. J. Linehan Jr.</i>	M.D.						
PHYSICIAN'S NAME (Type) F. J. LINEHAN JR., LCDR MC USN U. S. Naval Hospital, Bethesda, Maryland.							
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 5-29-59	22c. NAME OF CEMETERY OR CEMETORY Arlington National			22d. LOCATION (City, town, or county) (State) Arlington Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Muse and Reed <i>J. L. Muse</i>				ADDRESS Leesburg, Virginia	24a. REC'D BY REGISTRAR DATE JUN 1 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur J. Trahan</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

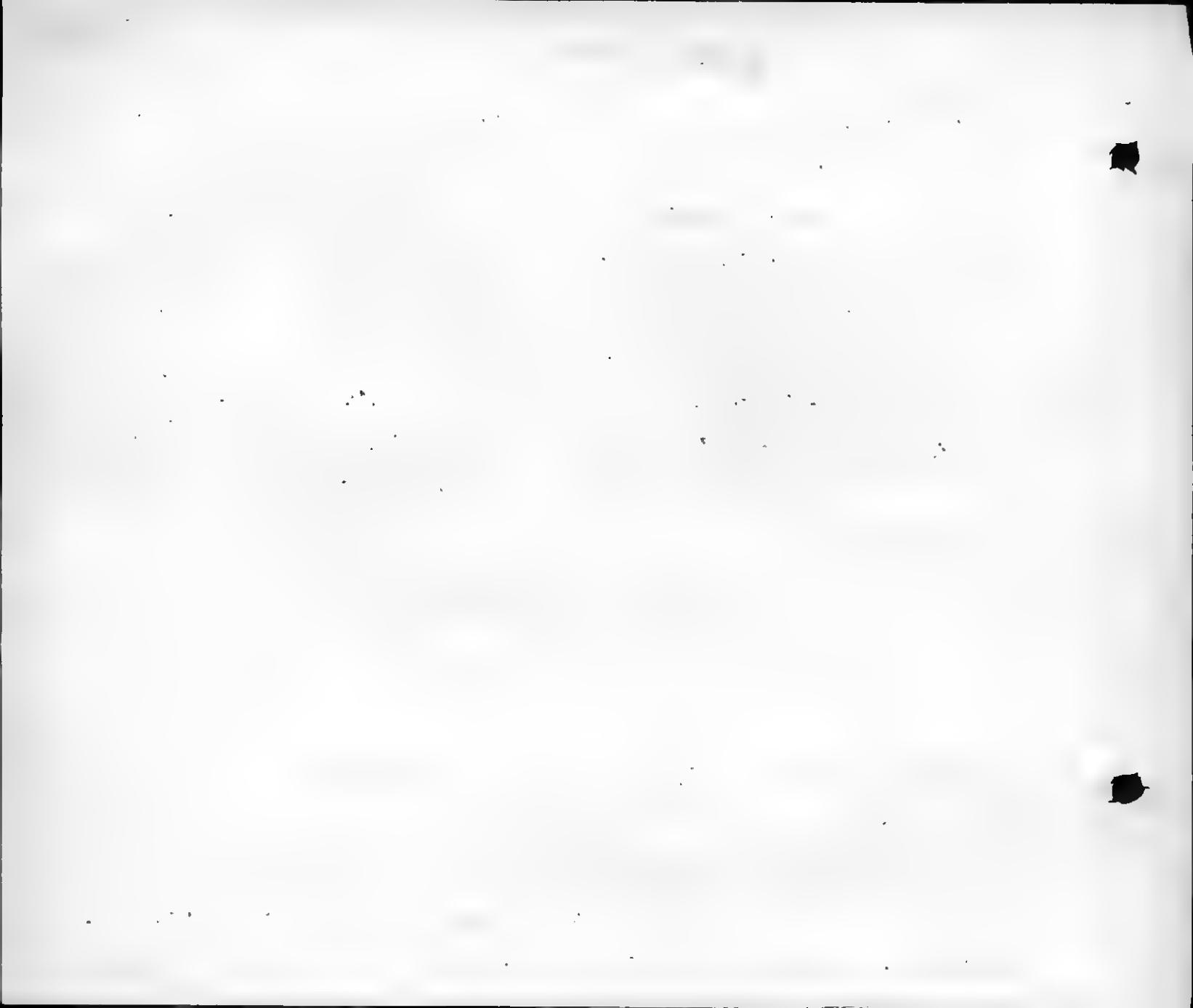
5766 CERTIFICATE OF DEATH

05747

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 3 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		d. STREET ADDRESS CIRCLE DRIVE, GLEN HILLS			
3. NAME OF DECEASED (Type or print) ISABEL LIVINGSTONE FOX		First	Middle	Last	4. DATE OF DEATH 5 5 1959	Month	Day	Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1894	9. AGE (In years last, birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 1	Days 13	Hours 0	IF UNDER 24 HRS Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.		11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WALTER WOLSTENHOLM		14. MOTHER'S MAIDEN NAME SARAH BAGSHAW - WOLSTENHOLM		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-22-8074		INFORMANT CLIFFORD LIVINGSTONE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).]		PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 199.2		DUE TO Carcinoma c Metastasis		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last.		{ (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) SHANES		(County) Montgomery	(State) Md.
21. I certify that I attended the deceased from Jan 3, 1958 to present , that I last saw the deceased alive on 3 May, 1959 , and that death occurred at 12:15 PM from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Shanes Mill Rd.		DATE SIGNED 5/8/59	
ACTUAL SIGNATURE Marvin M. Gibson									
PHYSICIAN'S NAME (Type) Marvin M. Gibson									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/8/59		22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Mausoleum		22d. LOCATION (City, town, or county) Prince George Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 7 '59		24b. REGISTRAR'S SIGNATURE Arthur & Anna			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 21 Film 212 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05748

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SENeca MD.		5767	MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Virginia		Reg. Dist. No.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Potomac River)		c. LENGTH OF STAY IN 1b		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 2206 Cherry Drive		83 x -3					
3. NAME OF DECEASED (Type or print)		First John	Middle F	4. DATE OF DEATH May 2 '1959		Month May	Day 2	Year '1959			
5. SEX M.		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1929		9. AGE (In years last birthday) 30 yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME unk		14. MOTHER'S MAIDEN NAME unk									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Drowning				INTERVAL BETWEEN ONSET AND DEATH 15 min.					
850X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Motor boat he was driving swamped in mid river, and he was unable to swim to shore		20c. TIME OF INJURY 7:30 a.m. May 2, 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River		(County) Seneca	(State) Montg. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John G. Ball		NAME (Type) John G. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7 May 1959					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 12, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington, Va.					
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home		ADDRESS 816 H St. N.E. Wash. D.C.		24a. REC'D BY REGISTRAR DATE MAY 12 '59		24b. REGISTRAR'S SIGNATURE Orville S. Knapp					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5768

CERTIFICATE OF DEATH

05749

Reg. Dist. No.

1. PLACE OF DEATH
o COUNTY

Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE

Md

b. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural—germantown

Length of stay in 1b
45 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Germantown, Md

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

d. STREET ADDRESS

Rural

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First Cornelius

Middle Martin

Last Frize

4. DATE
OF
DEATH

Month May

Day 25

Year 1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)
yrs10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)IF UNDER 1 YEAR
Months 7 Days 2 Hours 2 Min.

laborer

WIDOWED DIVORCED

Oct-23-1872 82

11. BIRTHPLACE (State or foreign country)

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Della Reed

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

95-07-7544 Ruth V. Frize, Rural Germantown, Md

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

cerebral accidents (year)

INTERVAL BETWEEN
ONSET AND DEATH
8 years

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

mental deterioration

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from _____, 1954, to May-25-1959, that I last saw the deceased
alive on May-24-1959, and that death occurred at 5:56 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

William C. Miller

M.D.

PHYSICIAN'S
NAME (Type)

William C. Miller

Gaithersburg, Md

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)
Gaithersburg, Md

Burial

5-28-59

St. Rose Cemetery

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

316 Diamond Ave.

DATE JUN 1 '59

Arthur S. Turner

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician.
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

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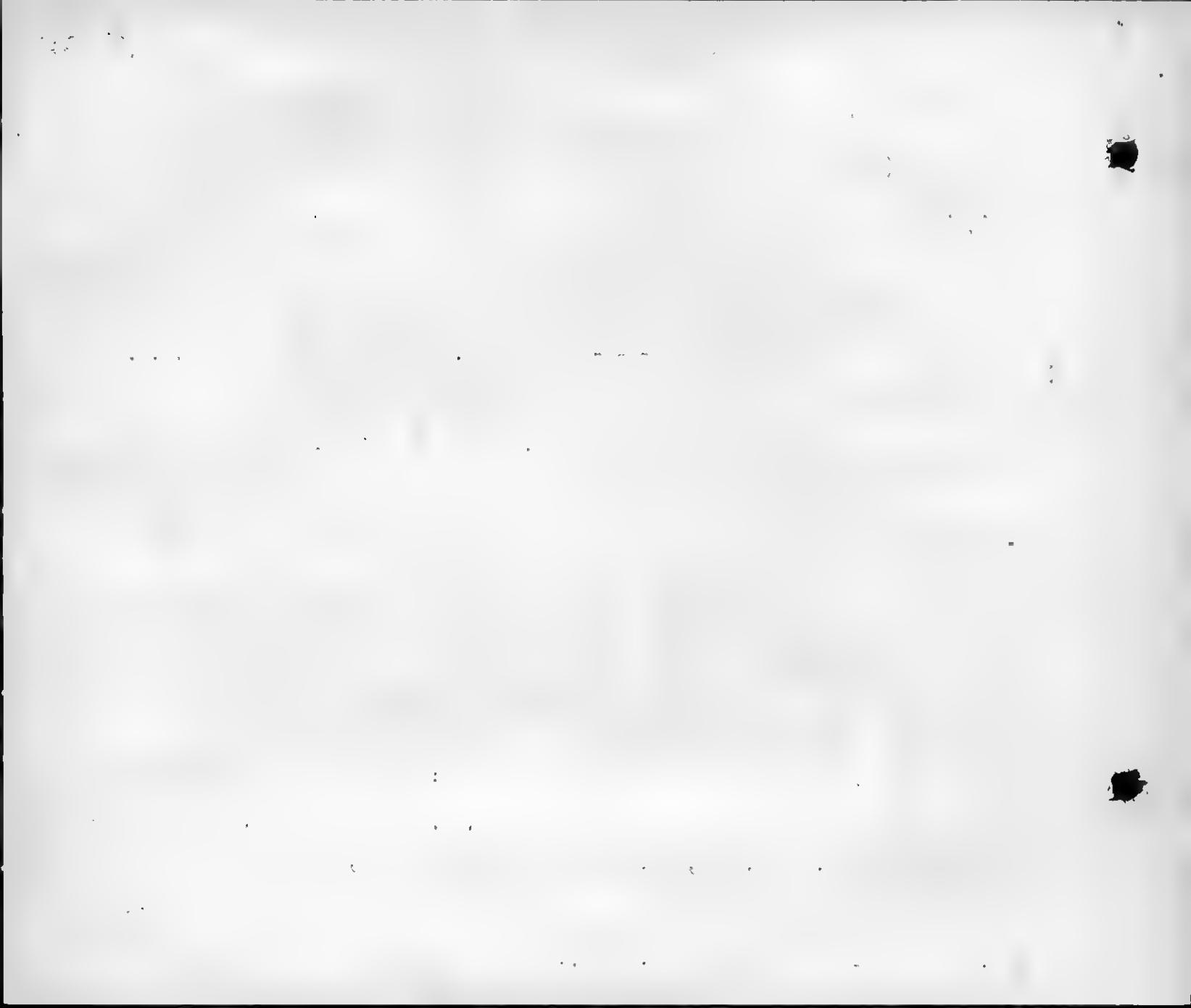
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05750

5769 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) 31 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. STREET ADDRESS 936 Madison Street	
3. NAME OF (Type or print) Roscoe Flabious GRADY		4. DATE OF DEATH May 15 1959	Month Day Year
S. SEX Male	5. COLOR OR RACE Caucasian	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11. BIRTHPLACE (State or foreign country) No. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jones GRADY	
14. MOTHER'S MAIDEN NAME Mary Jane (Unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI	
16. SOCIAL SECURITY NO 579 05 9631		17. INFORMANT Mrs. Amy Grady (Wife), same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 14, 1959, to May 15, 1959, that I last saw the deceased alive on May 15, 1959, and that death occurred at 9:50P M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>John W. Troy</i> ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 5-16-59			
PHYSICIAN'S NAME (Type) John W. TROY, CDR, MC, USN		Bethesda 14, Maryland	
22b. BURIAL CREMATION, REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORIALY 5-29-1959 Arlington National	
22d. LOCATION (City, town, or county) Arlington		(State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers, 1400 Chapin St., N.W., Wash, DC		24a. REC'D BY REGISTRAR DATE MAY 19 '59	
24b. REGISTRAR'S SIGNATURE <i>John S. Koenig</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5770 CERTIFICATE OF DEATH

Reg. Dist. No.

05751

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.		b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 56		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 18324 - 16th STREET.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8324 - 16th STREET				d. STREET ADDRESS 18324 - 16th STREET.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MILDRED ROWLEY		First MILDRED	Middle ROWLEY	Last GRAHAM	4. DATE OF DEATH MAY 13 1959	Month MAY	Day 13	Year 1959
5. SEX F		6. COLOR OR RACE LN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 28, 1904		9. AGE (In years last birthday) 54 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FISCAL CLERK		10b. KIND OF BUSINESS OR INDUSTRY DEPT. OF JUSTICE		11. BIRTHPLACE (State or foreign country) ELMIRA, NEW YORK		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME TIMOTHY ROWLEY		14. MOTHER'S MAIDEN NAME MABLE HORTON						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 577-09-6965		17. INFORMANT JOHN W. GRAHAM, 8324 16th ST. 55 MD		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X		DUE TO acute congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 1 hr.				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO degenerative heart disease		(c)				30 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 7852 16th St. NW	(County) Washington, D.C.	
21. I certify that I attended the deceased from Tele , 1958, to May 13, 1959 , that I last saw the deceased alive on May 9, 1959 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7852 16th St. NW Washington, D.C.								
ACTUAL SIGNATURE H. F. Kreuzburg		DATE SIGNED 5/13/59						
PHYSICIAN'S NAME (Type) H. F. Kreuzburg								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St. NC		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

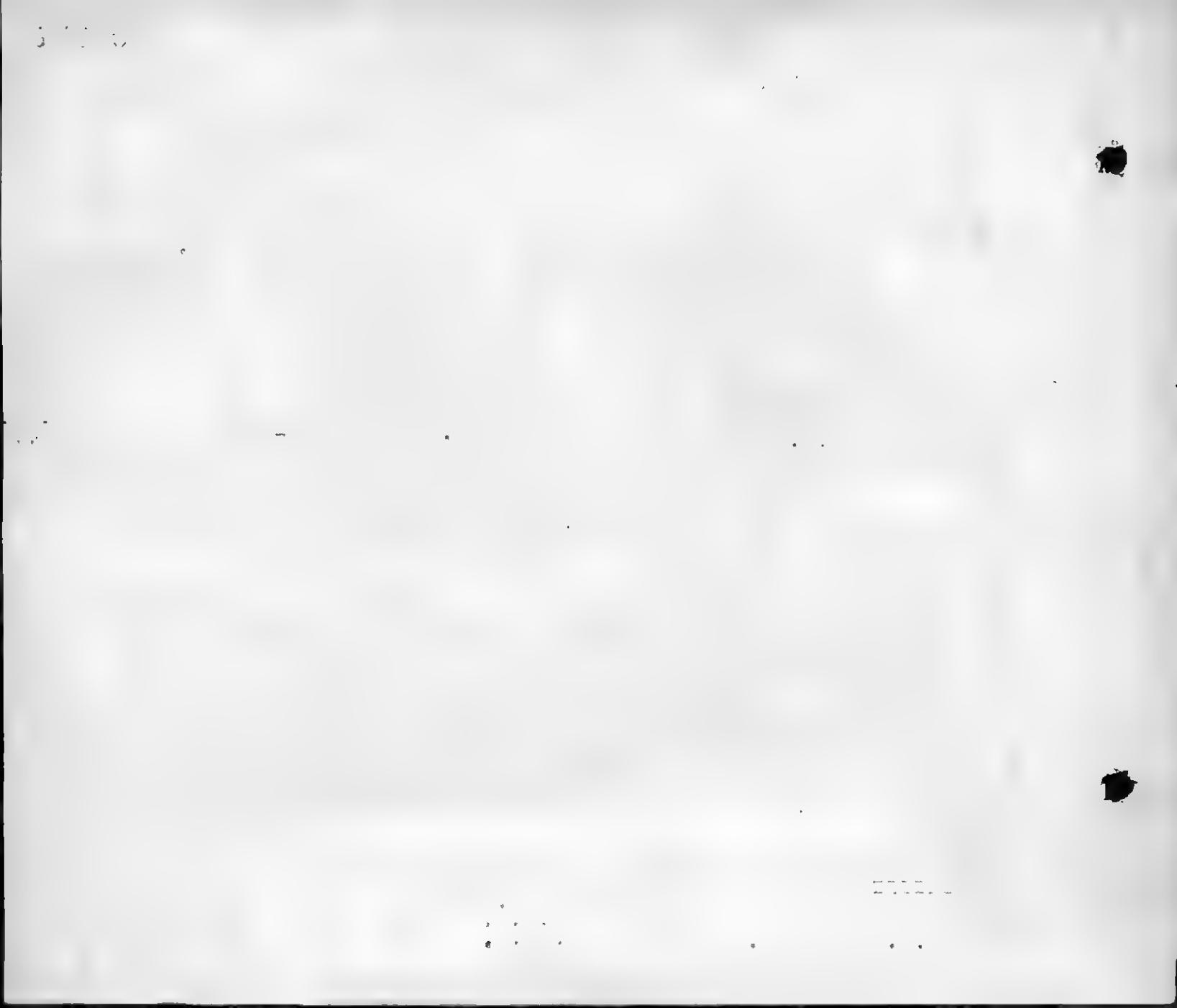
5771

CERTIFICATE OF DEATH

05752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1210 Highland Drive				d. STREET ADDRESS 1210 Highland Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First John	Middle Mathew	Last Gullick	4. DATE OF DEATH May 2, 1959	Month May	Day 2	Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/14/1887	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? Silver Spring, Md.		
13. FATHER'S NAME Joseph Gullick		14. MOTHER'S MAIDEN NAME Susan Kushner						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO. W.W.I		17. INFORMANT Milton P. Birthright-8712 Colesville Rd.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		causative heart failure				INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
		anterior sclerotic heart disease				5 yrs		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
				19				
21. I certify that I attended the deceased from alive on		March 27, 1957, to		March 2, 1957		that I last saw the deceased and that death occurred at 11 A.M. from the causes and on the date stated above.		
ACTUAL SIGNATURE H.F. Kreuzburg				ADDRESS (Street, city or town, state) 7852 16th & 20th St., N.W.		DATE SIGNED 5/2/59		
22a. BURIAL, CREMATION, REMOVAL (SPECIES) 5/6/59		22b. DATE THEREOF 5/6/59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat. Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)		
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.		ADDRESS Wash. D. C.		24a. REC'D BY REGISTRAR DATE MAY 5 '59		24b. REGISTRAR'S SIGNATURE Orlma S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05753

5772 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 77 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Logan		d. STREET ADDRESS General Delivery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Howard	Middle James	Last Hager	4. DATE OF DEATH	Month May	Day 29, 1959
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1907	9. AGE (in years last birthday) 51 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Jim Hager		14. MOTHER'S MAIDEN NAME Cora Kenser					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 236-03-9539		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 1 day			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Pneumonia		1 day			
		DUE TO Coronary Arteriosclerosis		Years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic Lymphocytic Leukemia					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from March 13, 1959, to May 29, 1959, that I last saw the deceased alive on May 29, 1959, and that death occurred at 6:45 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Nathan S. Taylor</i> M.D. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5-30-59 PHYSICIAN'S NAME (Type) Nathan S. Taylor, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 5/30/59	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 2901 14th St. N.W. The S.H. Hines Co. Washington 9, D.C.		22d. LOCATION (City, town, or county) Logan, West Virginia		(State)
23. FUNERAL DIRECTOR'S SIGNATURE VS A15 (4) ISM 10/57		24a. REC'D BY REGISTRAR DATE JUN 2 '59		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5773

CERTIFICATE OF DEATH

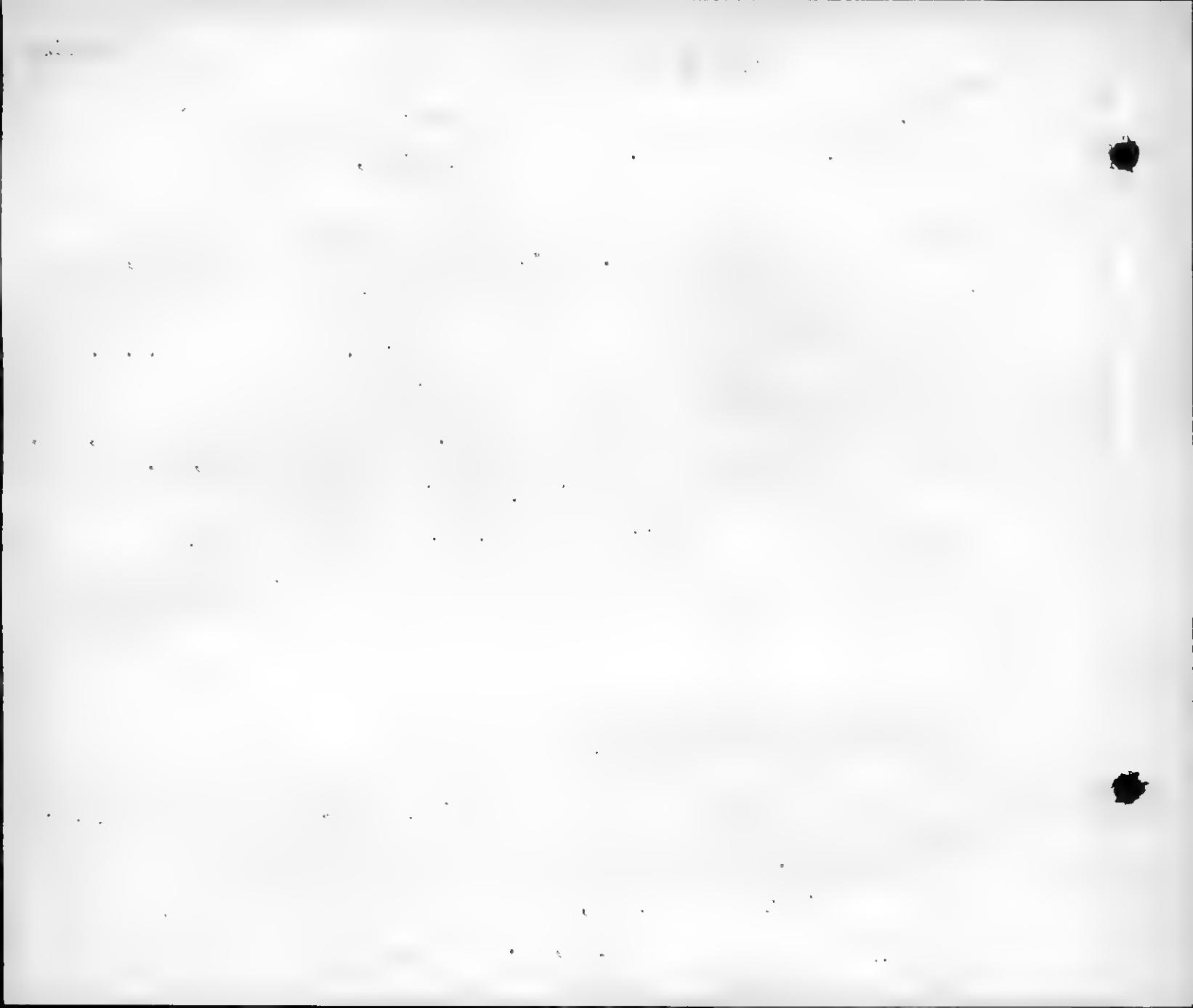
Reg. Dist. No.

05754

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville, (RoRall)		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD		First	Middle	Last	4. DATE OF DEATH May 8 1959	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1886	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland,		12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME Wallace Hamilton		14. MOTHER'S MAIDEN NAME Alice Baker							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT		Address Florence Hebron 4507 Rhode Island, Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident		DUE TO (b) Arteriosclerosis, Generalized		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Poolesville, Md.	(County) Montgomery Co., Md.	(State) Md.			
21. I certify that I attended the deceased from _____, June , 19 54 , to 8 May , 19 59 , that I last saw the deceased alive on 8 May , 19 59 , and that death occurred at Poolesville, Md. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Poolesville, Md.		DATE SIGNED 8 May 59					
ACTUAL SIGNATURE Gordon M. Smith									
PHYSICIAN'S NAME (Type) Gordon M. Smith									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/12/59	22c. NAME OF CEMETERY OR CREMATORIAL Elijah,		22d. LOCATION (City, town, or county) Poolesville, Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Haas			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item No. File No. 3243 6-2-59 et
5774 CERTIFICATE OF DEATH

05755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Delaware		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 43/11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederica		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Della		First	Middle	Last	4. DATE OF DEATH May 29, 1959	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1897	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Midwife		10b. KIND OF BUSINESS OR INDUSTRY Medical		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Enoch Ferrell								
14. MOTHER'S MAIDEN NAME Florence Neu zum								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No If yes, give war or date of service								
16. SOCIAL SECURITY NO. 17. INFORMANT None The Medical Record Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Congestion + Atelectasis</i> INTERVAL BETWEEN ONSET AND DEATH 2040 36 hrs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>Chronic Lymphocytic Leukemia</i> 12-14 mos.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from April 16, 1959, to May 29, 1959, that I last saw the deceased alive on May 29, 1959, and that death occurred at 11:58 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Habib Bacchus M.D. The Clinical Center 5-30-59 National Institutes of Health								
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Habib Bacchus, M. D.		Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Trans & Burial 6-2-59		22b. DATE THEREOF 6-2-59		22c. NAME OF CEMETERY OR CREMATORIAL Catawba Catawba W. Va		22d. LOCATION (City, town, or county) Catawba W. VA (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Pumphrey 7557 Wisc Ave Beth Md		ADDRESS		24a. REC'D BY REGISTRAR Oathie S. Trahan		24b. REGISTRAR'S SIGNATURE		
				DATE JUN 2 '59				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5775 CERTIFICATE OF DEATH

Reg. Dist. No.

05756

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE [Where deceased lived if institution: Residence before admission] a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 49 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1000 Massachusetts Avenue, NW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Jo	Last Harrison	4. DATE OF DEATH May	Month 10	Day 19	Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1907	9. AGE (In years last birthday) 51	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Manager		10b. KIND OF BUSINESS OR INDUSTRY Perpetual Bldg. Ass'n		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME William M. Moran		14. MOTHER'S MAIDEN NAME Marion Kinter					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-12-1787		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause of death for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 223X		Acoustic Neuroma, left		INTERVAL BETWEEN ONSET AND DEATH 1-2 years			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Chronic Pyelonephritis, bilateral		1-2 years			
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last.		Bronchopneumonia, bilateral		24 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 22, 1959, to May 10, 1959, that I last saw the deceased alive on May 10, 1959, and that death occurred at 8:25a.m., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Edward J. Laskowski, M.D.</i> M.D. The Clinical Center 5/10/59							
PHYSICIAN'S NAME (Type) EDWARD J. LASKOWSKI, M.D.		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL/CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/13/59		22c. NAME OF CEMETERY OR CREMATORIUM GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND (State)	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAY 15 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

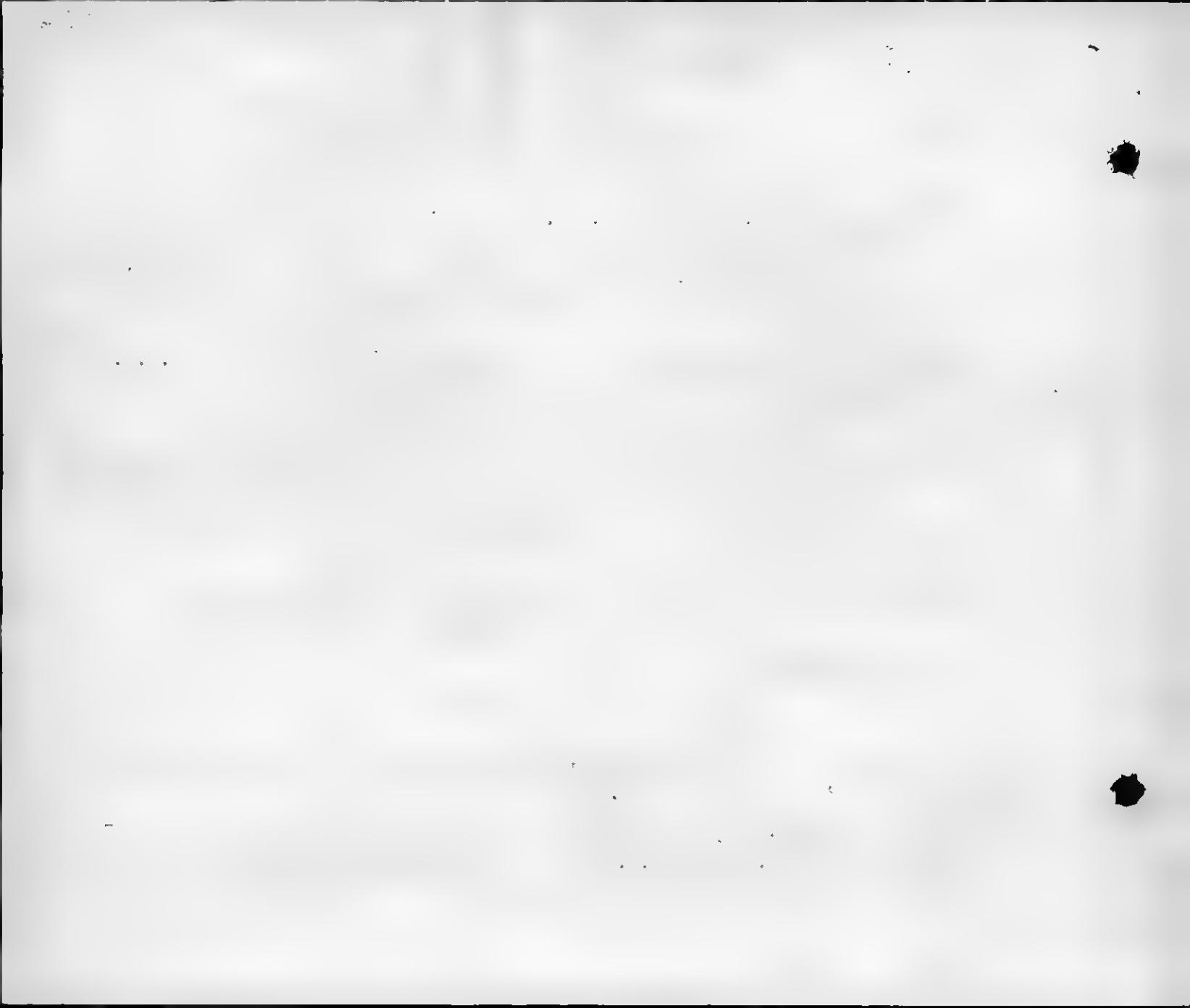
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5776 CERTIFICATE OF DEATH

05757

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE Pennsylvania		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conemaugh		d. STREET ADDRESS 1110 William Penn Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen		First	Middle	4. DATE DEATH	Month	Day	Year
				11	May	26	1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 3, 1925	9. AGE (In years last birthday) 33	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Webster Sweeney				14. MOTHER'S MAIDEN NAME Agatha McGuire			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Bleuematite heart disease. - Probable embolization during initial Commissurotomy				INTERVAL BETWEEN ONSET AND DEATH years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from May 17, 1959 to May 26, 1959 that I last saw the deceased alive on May 26, 1959 and that death occurred at 12:00P M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>William W. Pfaff</i>						ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) William W. Pfaff, M.D.						DATE SIGNED 5-26-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/29/59		22c. NAME OF CEMETERY OR CREMATORIUM St. John's Cem.		22d. LOCATION (City, town, or county) Johnstown, Penna. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAY 28 '59		24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05758

5777

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 5100 T Street, S. E.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Charles	Middle Edward	Last HEINEMAN	4. DATE OF DEATH May 6 1959	Month May	Day 6	Year 1959
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-86	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Christian HEINEMAN		14. MOTHER'S MAIDEN NAME Fanny EIKEE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. 1902 - 1945		17. INFORMANT (w) Mrs. Stella Heineman, same as #2 above		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Hypertension (c) DUE TO Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 months 10 years End of life.		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o.m. p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from April 27, 1959, to May 6, 1959, that I last saw the deceased alive on May 6, 1959, and that death occurred at 8:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. U. S. Naval Hospital, NMNC ACTUAL SIGNATURE J. M. YOUNG, Jr., MC, USN PHYSICIAN'S NAME (Type)		DATE SIGNED 4-7-59						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-12-59	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	22d. LOCATION (City, town, or county) Arlington	(State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 517 11th St., S.E., Washington, DC		ADDRESS George & Dean	24a. REC'D BY REGISTRAR MAY 8 '59 DATE	24b. REGISTRAR'S SIGNATURE Curtis S. Thorne				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5778 CERTIFICATE OF DEATH

Reg. Dist. No.

05759

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 28 2 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. STREET ADDRESS 6102 SWANSEA ST.	
3. NAME OF DECEASED (Type or print) Eric		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 14, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME PER		14. MOTHER'S MAIDEN NAME MARY JANE SELLECT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Per Hellekjaer - 6102 - Swansea St.		Address Beaufort	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Secondary pneumonia			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/14</u> , 19 <u>59</u> to <u>5/15</u> , 19 <u>59</u> that I last saw the deceased alive on <u>5/15</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Robert E. Stadelman</u> M.D. ADDRESS (Street, city or town, state) <u>1717 N St., N.W. 5/16/59</u> DATE SIGNED <u>5/16/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/18/59	
22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		22d. LOCATION (City, town, or county) Suitland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR MAY 19 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

\$199

05760

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 908 Viers Mill Rd.		d. STREET ADDRESS 1724 Grandin Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) IDA		First MAY	Middle HENLEY
4. DATE OF DEATH May 23, 1959		Month May	Day 23
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Dec. 22, 1888		9. AGE (in years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months 5 Days 1 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Edward Henley		14. MOTHER'S MAIDEN NAME Elizabeth Butt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Arthur R. Henley Nephew		Address Damascus, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hypertension (c) DSCVD		INTERVAL BETWEEN ONSET AND DEATH 1m 4s	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C. & Y. 7.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Stephen N. Jones		M.D. 5/24/59 809 Viers Mill Rd. Rockville, Maryland 5-24-59	
PHYSICIAN'S NAME (Type) Stephen N. Jones		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 5-25-59		22c. NAME OF CEMETERY OR CREMATORIAL Rockville Cemetery	
22d. LOCATION (City, town, or county) Montgomery County, Md.		24a. REC'D BY REGISTRAR DATE MAY 27 '59	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24b. REGISTRAR'S SIGNATURE Arthur S. Finch	



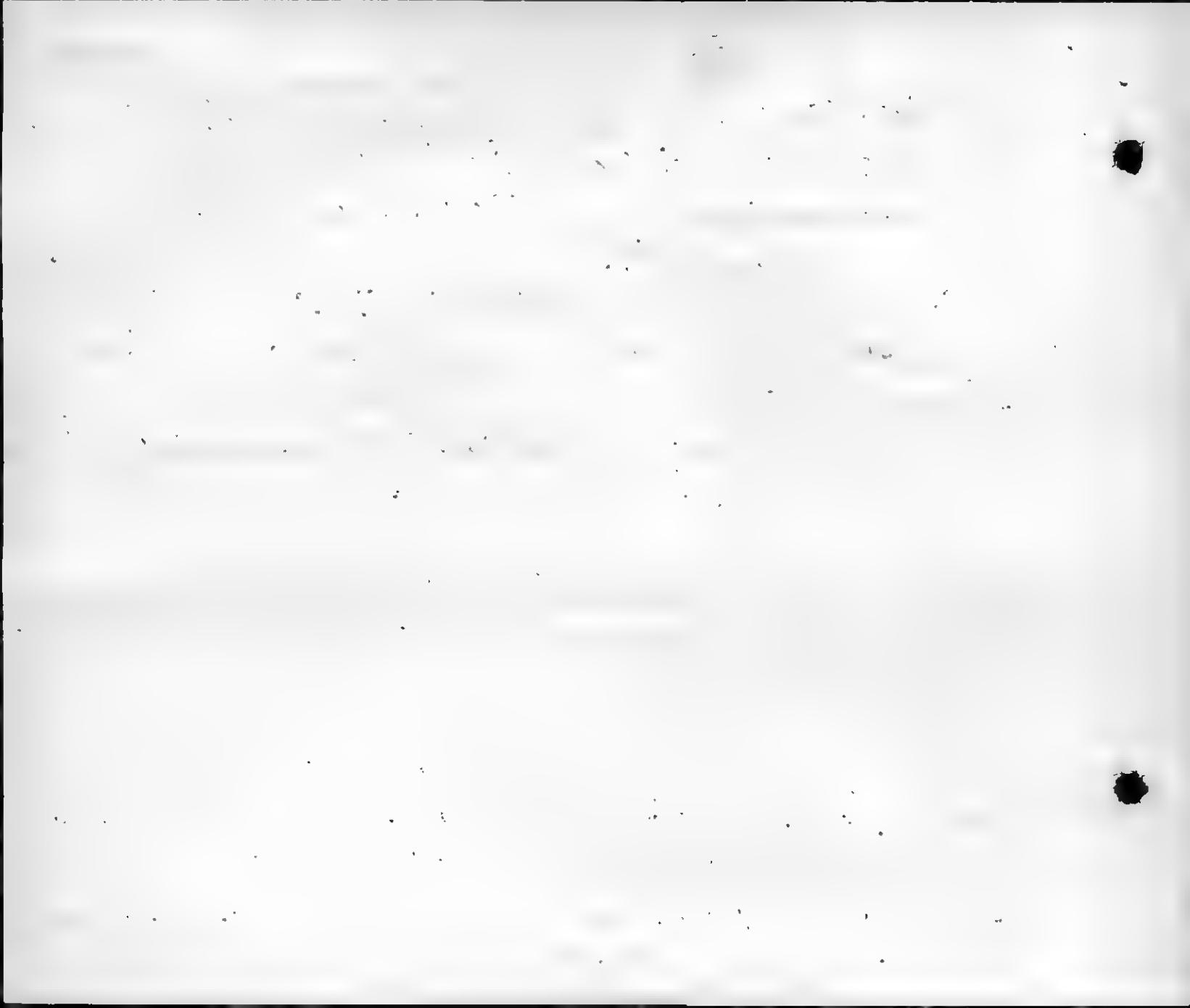
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5779 CERTIFICATE OF DEATH

Reg. Dist. No. 05761

1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>D. O. A.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburbans</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Molly</i>	Middle <i>M.</i>	Last <i>HENRY</i>
4. DATE OF DEATH	Month <i>5</i>	Day <i>1</i>	Year <i>1959</i>
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 2 1872</i>
9. AGE (In years last birthday) yrs <i>87</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>W. Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>Samuel Clark</i>		
14. MOTHER'S MAIDEN NAME <i>Lydia Kearmf</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <i>No</i>		
16. SOCIAL SECURITY NO. <i>Unknown</i>	INFORMANT <i>Mrs Eddie Hickman Dauphre - Same</i>	Address <i>Address</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tuberculosis</i> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Breast</i> DUE TO (c) <i>Chronic Bronchitis</i> INTERVAL BETWEEN ONSET AND DEATH <i>15</i> <i>2</i> <i>months</i> <i>July 1</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec. 1, 1958</i> to <i>May 8, 1959</i> that I last saw the deceased alive on <i>5/8/59</i> , and that death occurred at <i>7:00 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Stephen N. Jones</i> M.D. ADDRESS (Street, city or town, state) <i>Rockville, Md.</i> DATE SIGNED <i>5/8/59</i>			
PHYSICIAN'S NAME (Type) <i>Stephen N. Jones</i>		22a. BURIAL CREMATION REMOVAL (Specify) <i>Burial-Transit</i>	
22b. DATE THEREOF <i>5/12/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Carmal Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Berkley Co.</i>		(State) <i>W. Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		24a. REC'D BY REGISTRAR DATE <i>May 12 '59</i>	
ADDRESS <i>Bethesda, Maryland</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5780

CERTIFICATE OF DEATH

05762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Washington DC</i>				c. LENGTH OF STAY IN lb 12 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) 5320 Marilyn Drive, Glenman PK.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Washington DC</i>			
5. SEX <i>Male</i>				6. COLOR OR RACE <i>White</i>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>Apr. 24, 1880</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer (farm)</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>			
11. BIRTHPLACE (State or foreign country) <i>Simpson, Minn.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>			
13. FATHER'S NAME <i>John Higgins</i>				14. MOTHER'S MAIDEN NAME <i>Donative</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. —			
17. INFORMANT <i>Son</i>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>gastric dilatation</i> DUE TO <i>14.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cerebral thrombosis</i> DUE TO (c) <i>generalized arteriosclerosis</i>			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hyper tension</i>			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 1, 1959</i> to <i>May 14, 1959</i> that I last saw the deceased alive on <i>April 30, 1959</i> , and that death occurred at <i>10:15 AM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Wilfred R. Ehrmantrout, M.D. 4890 Battery Lane, Bethesda, Md.</i>		DATE SIGNED <i>5/19/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-16-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Olivet Cemetery</i>		22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Collins</i>				24a. REC'D BY REGISTRAR ADDRESS Wash. D. C. Francis J. Collins 3821 14th. St. N.W.			
				24b. REGISTRAR'S SIGNATURE <i>John S. Tracy</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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212010192011

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5781 CERTIFICATE OF DEATH

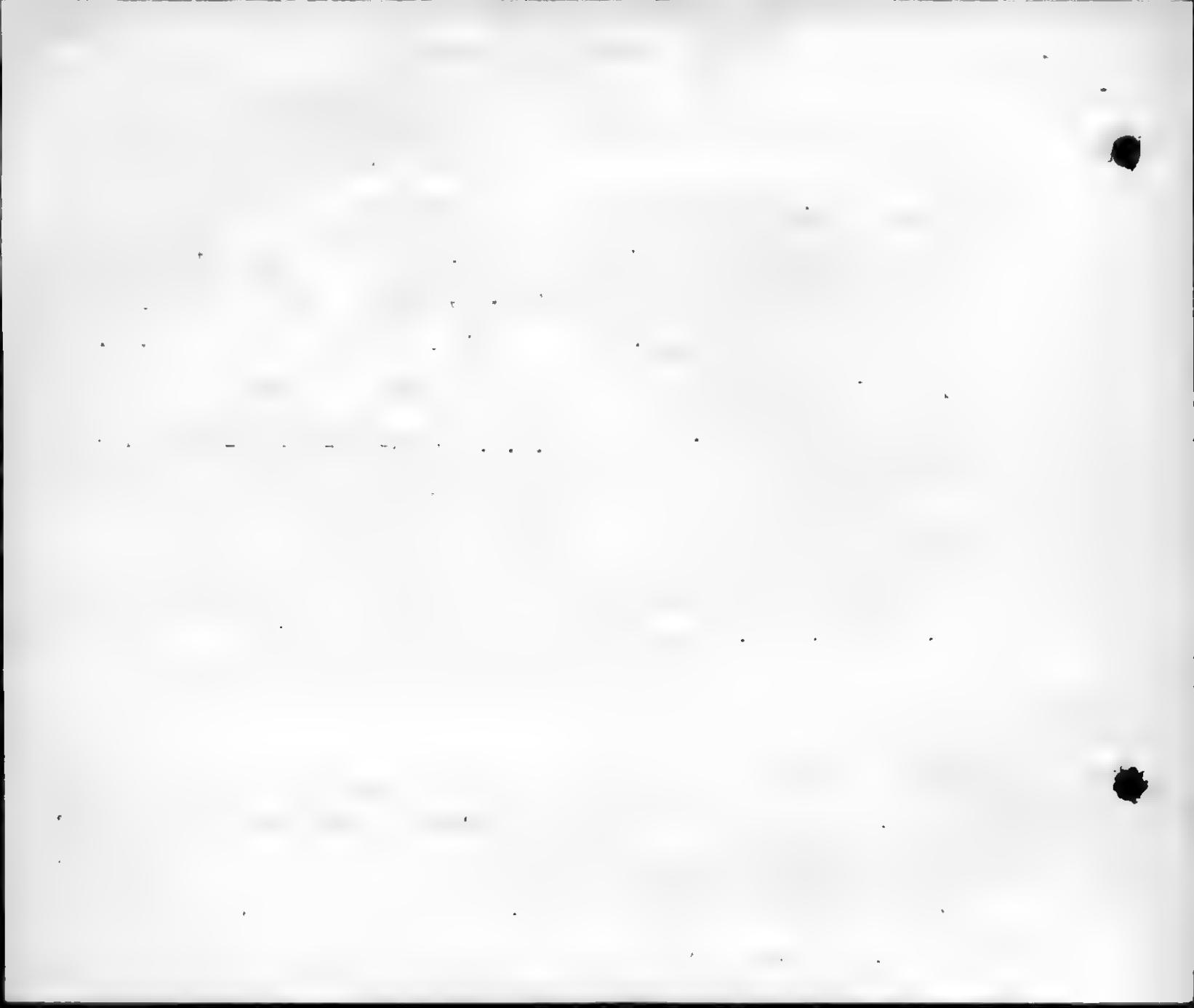
05763

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home		e. STREET ADDRESS 9616 Old Spring Road	
3. NAME OF DECEASED (Type or print) LILLIAN HUBBARD		4. DATE OF DEATH Month May 1,	Day Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Nov. 5, 1875	9. AGE (In years last birthday) 83 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Geneologist	11. BIRTHPLACE (State or foreign country) Rhode Island
13. FATHER'S NAME Hiram Wilbur Hubbard		14. MOTHER'S MAIDEN NAME Josephene Ferguson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		INFORMANT W.R.F. Adams-sin-in-law-same as 2d	ADDRESS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) *Patient under medical supervision (other than my own) at nursing home for 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 5320 M, from the causes and on the date stated above.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1, 1959 to May 1, 1959 , that I last saw the deceased alive on May 1, 1959 , and that death occurred at 5320 M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Donald Nelson M.D. 10620 Georgia Ave. Silver Spring			
ACTUAL SIGNATURE Donald Nelson		DATE SIGNED 5/1/59	
PHYSICIAN'S NAME (Type) Donald Nelson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/4/59	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory
22d. LOCATION (City, town, or county) Suitland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. ADDRESS Bethesda, Maryland	24b. REC'D BY REGISTRAR DATE MAY 4 '59
		24c. REGISTRAR'S SIGNATURE Arthur S. Krause	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

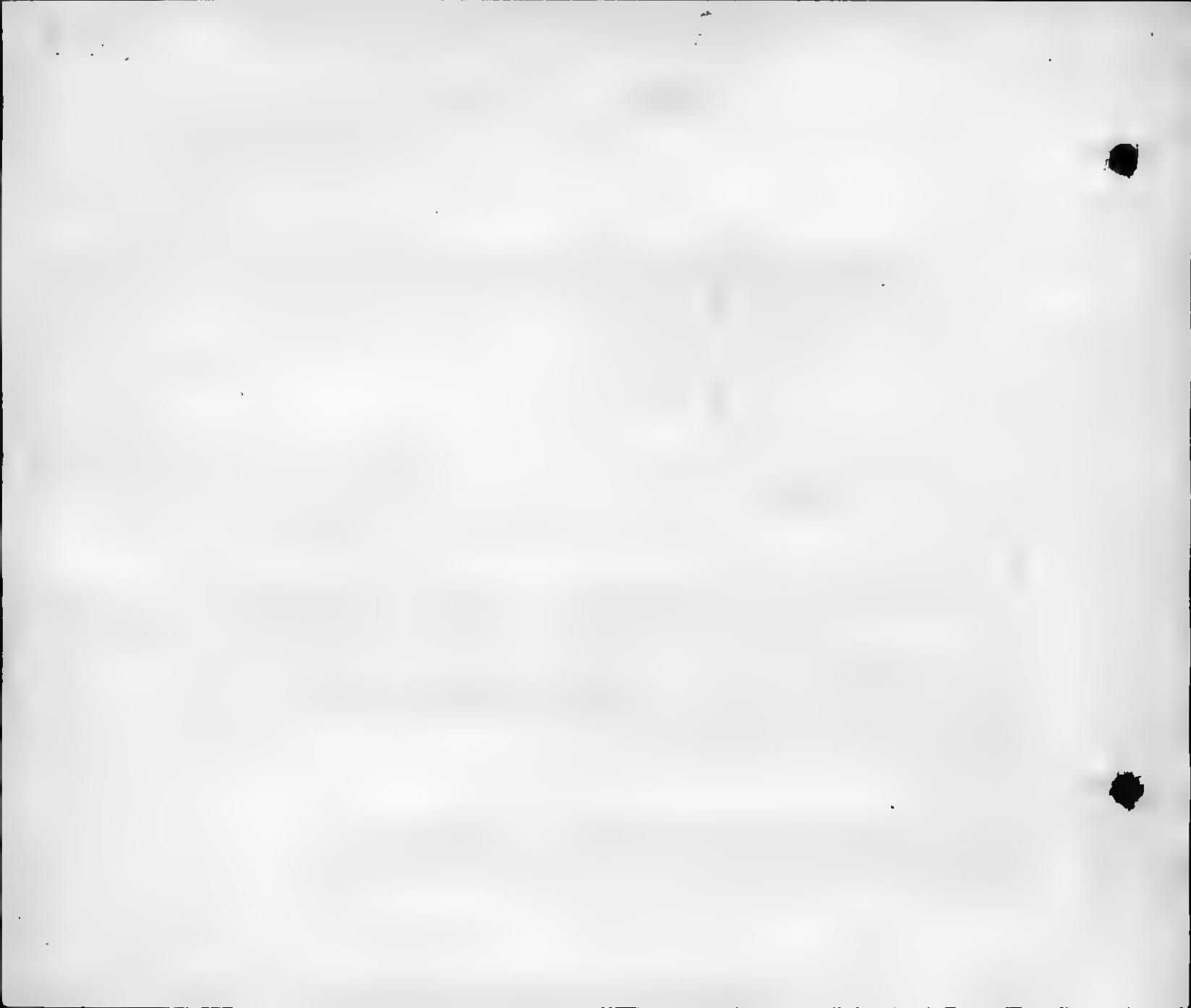
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
ITEMS 18-21 FILM 2

05764

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		5782	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MARYLAND	a. STATE b. COUNTY			
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		16 Silver Spring				
10512 Loraine Ave		10512 Loraine Ave				
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH		
Thaddeus Jerry Hopkins				May 26 1959		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (In years last birthday) 58 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3-5-1901		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Movie Projection				D.C.		U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Husband of Wm F. Hopkins		Maurice Hawkford				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		
				Wm E. Hopkins		101 S. Hampton Dr Silver Spring, Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH		
871.9		Barbiturate poisoning				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)				
DUE TO		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
Month, Day, Year 19				—		—
22. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)
Burial		5-23-59		George Washington Candler Prinie		George Maryland
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
DEAL FUN. Home 4812 Ga Ave New York				DATE JUN 3 '59		Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5726

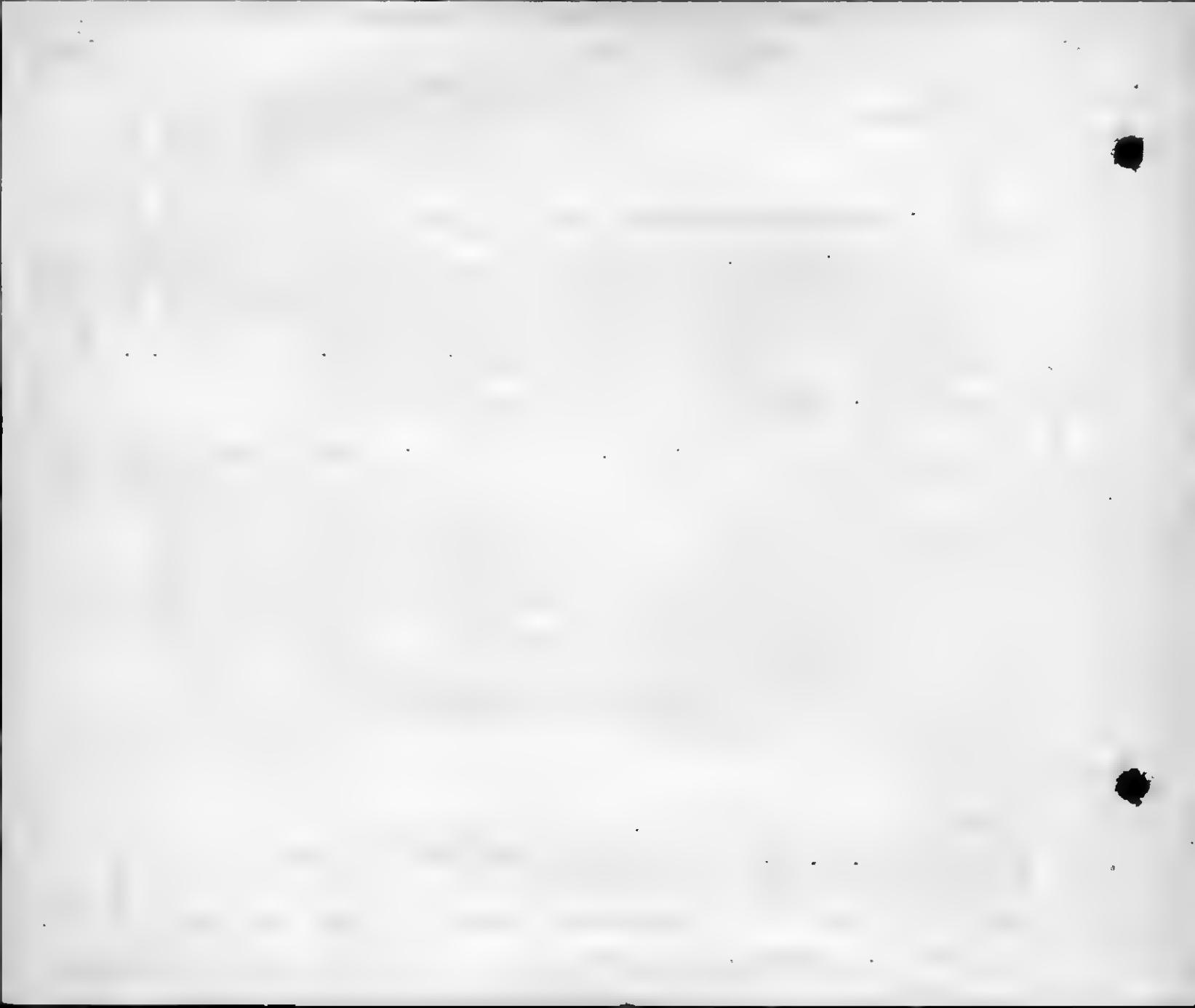
CERTIFICATE OF DEATH

Reg. Dist. No.

05765

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland - Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 228 E. Montgomery Avenue		d. STREET ADDRESS 802 Roxboro Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First CLIFORD L. HOWARD	Middle	Last	4. DATE OF DEATH May 22	Month Day Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-15-24	9. AGE (in years last birthday) 35 yrs.	IF UNDER 1 YEAR Months 3 Days 7 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Cliford L. Howard		14. MOTHER'S MAIDEN NAME Lucie Gallaher		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Address Catherine G. Howard - Item #2- Wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH Coronary occlusion 15 min					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 to 5-22 , 19 59 , that I last saw the deceased alive on 5/22/59 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. G. Hall 615 W. Montgomery Ave., Rockville, Maryland 5-22-59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-59		22c. NAME OF CEMETERY OR CREMATORIUM Darnestown Presby. Ch. Cem - Montgomery Co., Md.	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Krause					



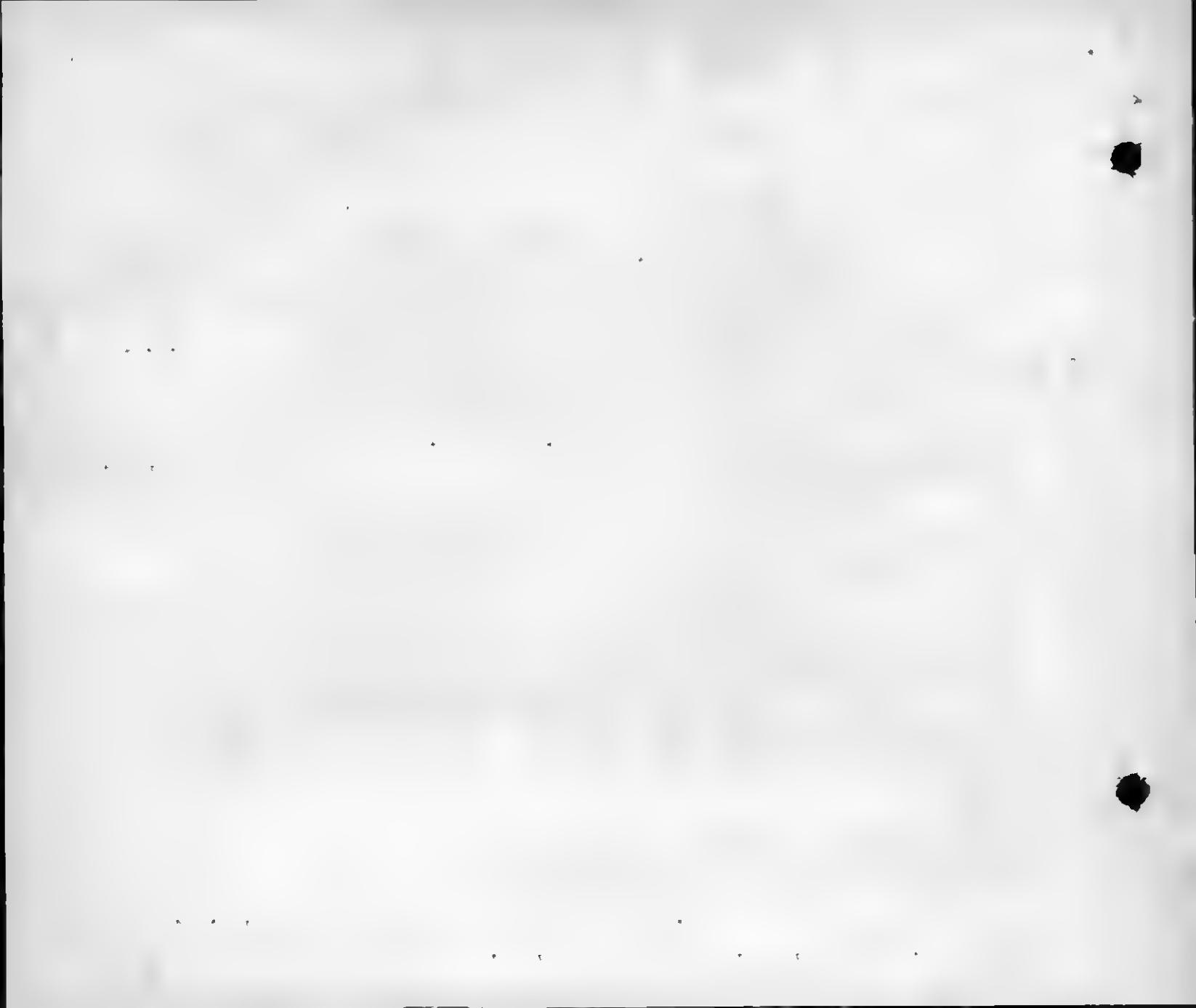
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5783 CERTIFICATE OF DEATH

115766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 56		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 424 SOUTHWEST DRIVE		d. STREET ADDRESS 424 SOUTHWEST DRIVE		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ESTHER		First O.	Middle IANNIELLO	Lost	4. DATE OF DEATH MAY	Month 21	Day Year 19 59
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/78	9. AGE (In years lost birthday) 81	10. IF UNDER 1 YEAR Months IF UNDER 24 HRS Days	11. IF UNDER 1 YEAR Hours	12. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME VINCENT OLIVIERI		14. MOTHER'S MAIDEN NAME JUSTINE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT Mrs. Harold E. Cropper, 424 Southwest Drive Silver Spring, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO — acute coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 1/5 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO — arteriosclerotic heart disease	(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 5-22-1959	(County) Washington, D. C.
21. I certify that I attended the deceased from		21. I certify that I attended the deceased from		21. I certify that I attended the deceased from		21. I certify that I attended the deceased from	
alive on		alive on		alive on		alive on	
ACTUAL SIGNATURE VERONICA Trowst.		ADDRESS (Street, city or town, state) 5-22-1959		DATE SIGNED			
22a. BURIAL, CREMATION, ENTOMBMENT		22b. DATE THEREOF 5/25/59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAY 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	
Raymond O. Ziska							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5784

CERTIFICATE OF DEATH

Reg. Dist. No.

05767

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG		c. LENGTH OF STAY IN 1b 11 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REST HAVEN CONVALESCENT HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON GROVE	
3. NAME OF DECEASED (Type or print) Arthur M Isherwood		4. DATE OF DEATH MAY 3 1959	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 11/11/84	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR (retired)		10b. KIND OF BUSINESS OR INDUSTRY D.C. Highway Dept.	
10c. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT ISHERWOOD		14. MOTHER'S MAIDEN NAME ISABELLA DARBY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Ruth K. Isherwood, 410 Brown St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 24x Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cardiac Asthma DUE TO (c) Cerebral Arteriosclerosis, Hypertension	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19, to <u>1959</u> , 3, 1959, that I last saw the deceased alive on <u>April 30, 1959</u> , and that death occurred at <u>Rest Haven M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Luciano I. Leal</u> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <u>Luciano I. Leal</u> <u>108 N. Frederick Ave.</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/6/59	
22c. NAME OF CEMETERY OR CREMATORIUM ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Jeske		24a. REC'D BY REGISTRAR MAY 5 1959 DATE	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur L. Stark	



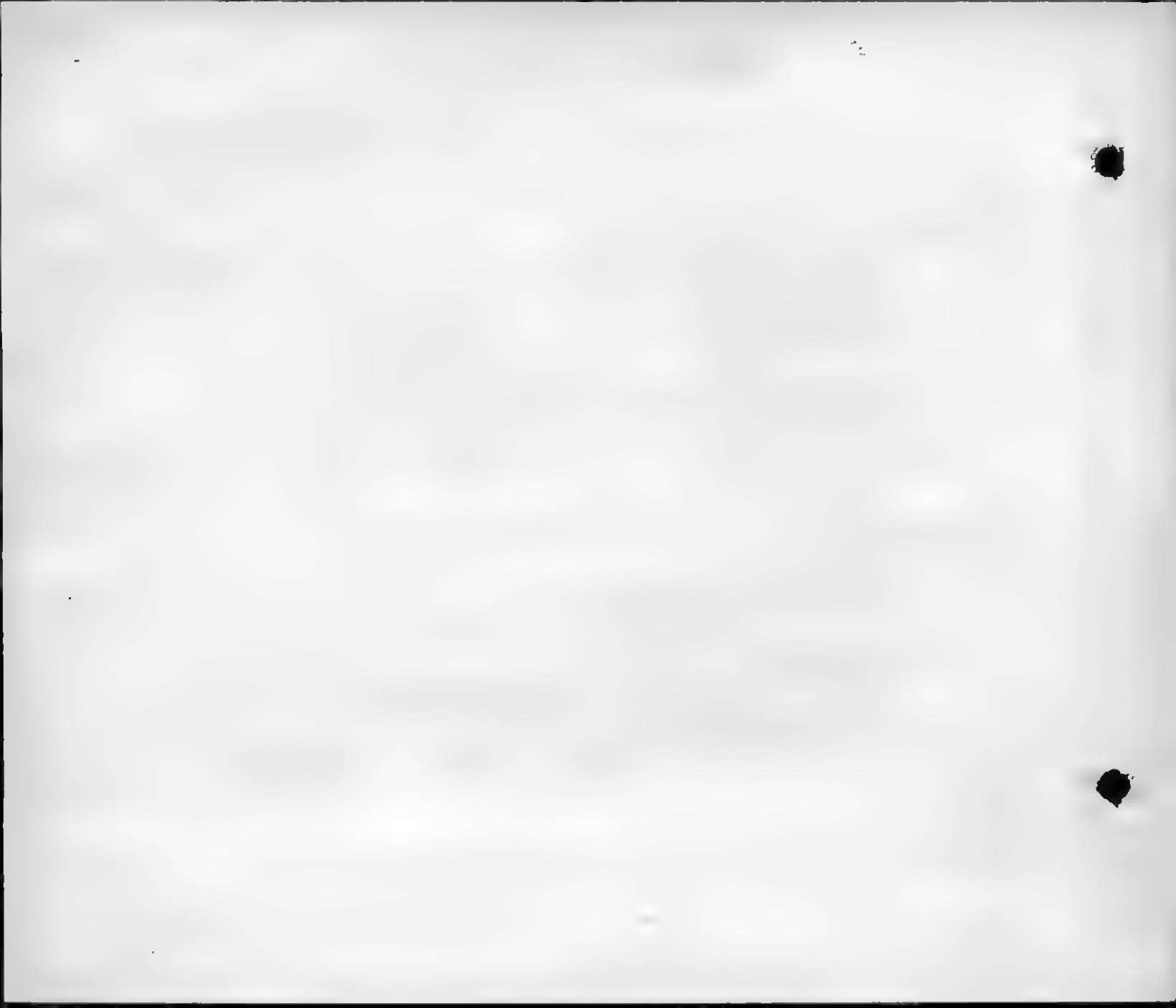
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05768

5715 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Montgomery		Maryland		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Takoma Park		Takoma Park		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		8402 Barron St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Washington Sanitarium & Hospital					
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month
Sherman Wesley Jack				5	2
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 64 yrs
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-4-94	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Plumber				Ohio	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? America	
William H. Jack		Mervie Mosher		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive failure			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		1 day			
DUE TO (b)		Ventricular fibrillation			
DUE TO (c)		Coronary thrombosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Diabetes mellitus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 14, 1959, to May 2, 1959, that I last saw the deceased alive on May 1 st , 1959, and that death occurred at 4:45 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 518 University Blvd. E Silver Spring, Maryland			
ACTUAL SIGNATURE EINO MAGI		DATE SIGNED 5/2/59			
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Prince George County, Md.	
May 4, 1959		George Washington Cemetery		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. J. Stollberg		ADDRESS 254 Carroll St. N.W. D.C.		24a. REC'D BY REGISTRAR DATE MAY 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur & Anna	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5785

CERTIFICATE OF DEATH

05769

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN lb 2 HR. 10 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DERWOOD		d. STREET ADDRESS 1175	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) IDA		First Middle —		4. DATE OF DEATH JACKSON		Month MAY	Day 16
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/1880	
9. AGE (In years last birthday) 179		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY		12. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN BOSWELL		14. MOTHER'S MAIDEN NAME ANNA PROCTOR		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) terinary Occlusion Arterio Sclerotic Heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10. CIVILIAN OF WHAT COUNTRY USA	
20. MEDICAL CERTIFICATION		21. I certify that I attended the deceased from <u>3/11</u> , 19 <u>59</u> , to <u>5/16/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/14/59</u> , 19 <u>59</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above ACTUAL SIGNATURE <u>X J. W. BIRD</u> ADDRESS <u>Sandy Spring, Md.</u> DATE SIGNED <u>5/17/59</u>		20. TIME OF INJURY Hour a.m. 19 p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)					
21. PHYSICIAN'S NAME (Type) J. W. BIRD, M. D.		22. NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify) Burial 5/20/59		22c. LOCATION (City, town, or county) Spencerville (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Shadon		22d. ADDRESS Rockville Rd.		24d. REC'D BY REGISTRAR DATE MAY 22 '59		24b. REGISTRAR'S SIGNATURE Orville S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

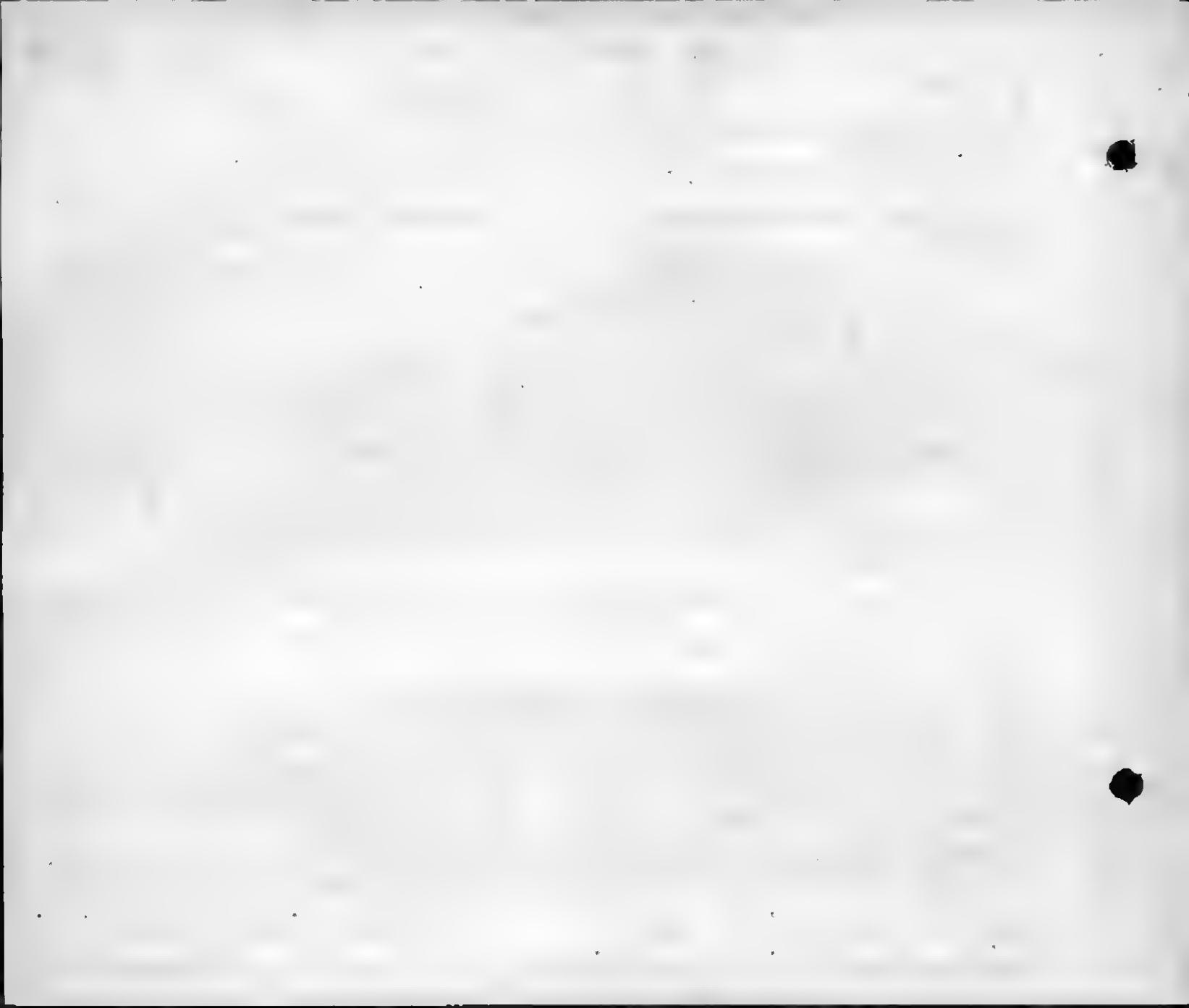
5786 CERTIFICATE OF DEATH

Reg. Dist. No.

05770

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
MONTGOMERY MARYLAND		Georgia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		b. COUNTY GORDON	
c. LENGTH OF STAY IN 1b 24 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colhoun (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 128 AMES ROAD		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
FEMALE		LUTISHA	ELIZABETH JACKSON
4. DATE OF DEATH		Month	Day
		MAY	27
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
FEMALE		white	JULY 25, 1874
8. DATE OF BIRTH		9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months Days Hours Min
WIDOWED		84 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Georgia
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William R. Lancaster		14. MOTHER'S MAIDEN NAME Betsy Ann Mahalia Pirkle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	17. INFORMANT MARTHA WILLS
		Address 128 Ames Rd, Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 7 days			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Carcinoma of the Pituitary Gland 6 1/2 years			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 12</u> , 1957, to <u>May 21</u> , 1959, that I last saw the deceased alive on <u>May 25</u> , 1959, and that death occurred at <u>3:25 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1806 Fox St, Hyattsville, Md. DATE SIGNED May 27th, 1959			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James L. Laubach		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF May 28th, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Cethcologa Cemetery	
22d. LOCATION (City, town, or county) Gordon Co. near Adairsville, Ga.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE JUN 1 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	





TO MEDICAL EXAMINER: This certificate should be signed within 24 hours of death. If any delay is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-troulli permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5787 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Kensington		18 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
3908 Mertford st		Kensington	
3. NAME OF DECEASED (Type or print)		f. STREET ADDRESS	
Milton		3908 Mertford st	
4. DATE OF DEATH		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
May 23 1959			
5. SEX		h. IF UNDER 1 YEAR Months Days Hours Min.	
Male		i. IF UNDER 24 HRS	
6. COLOR OR RACE		j. AGE (In years last birthday)	
col		54 yrs.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		k. BIRTHPLACE (State or foreign country)	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Md	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
labour		agriculture center	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Benz Jackson		Annie Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown)		16. SOCIAL SECURITY NO.	
(1 yrs. give war or date of service)		17. INFORMANT	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Rosie Jackson (wife) Street 2	
4-4-1 DUE TO		Acute congestive heart failure	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		b. DUE TO	
		c. DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Frank J. Boscourt FRANK J. Boscourt		DATE SIGNED 5-23-59	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 5/27/59	
22c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park,		22d. LOCATION (City, town, or county) Rockville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert R. Snodden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5788

CERTIFICATE OF DEATH

05772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>MAUDE</i>	Middle <i>AGNES</i>	Last <i>JENKINS</i>		
4. DATE OF DEATH	Month <i>May</i>	Day <i>11</i>	Year <i>1959</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>May 26, 1890</i>		
9. AGE (In years lost birthday) <i>68</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Dickinson Center, N.Y.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Wallace Jenkins</i>	14. MOTHER'S MAIDEN NAME <i>Elmira Clarke</i>	Address <i>Hospital Records</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>711-00-0000</i>	17. INFORMANT <i>Hospital Records</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema - acute</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>acute - Far advanced Rheumatoid</i> DUE TO (c) <i>arthritis + Total Deformity</i>	INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>May 19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Olney</i>	(County) <i>Md</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>Olney</i> , 1957, to <i>May</i> , 1959, that I last saw the deceased alive on <i>10 May</i> , 1959, and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>John Bosley Ziegler</i>	ADDRESS (Street, city or town, state) <i>Olney, Md</i>			DATE SIGNED <i>11 May 59</i>	
PHYSICIAN'S NAME (Type) <i>JOHN BOSLEY ZIEGLER</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>May 13, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Easton Cemetery</i>	22d. LOCATION (City, town, or county) <i>South Lancaster, Mass.</i>	(State) <i>Mass.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>	ADDRESS <i>234 East St.</i>	24a. REC'D. BY REGISTRAR DATE <i>MAY 13 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>		



1
FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for my files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

1074
1. DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for my files.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for my files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

105773

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

24 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Diane

YVONNE Jernigan

4. DATE
OF
DEATH

Month
May

Day
10

Year
1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

Female

White

WIDOWED

DIVORCED

May 30, 1953

5

yr

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Child

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Senadi, Japan

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis E. Jernigan

14. MOTHER'S MAIDEN NAME

Berry Lois WOODWARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Louis E. Jernigan

Address

Item #2

As above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

501X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Pneumonia

Encephalomalacia

Cardiac Arrest (During appendectomy) 23 days

INTERVAL BETWEEN
ONSET AND DEATH

21 days

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Pending

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY
Month, Day, Year
Hour
e. m.
p. m.

20d. INJURY OCCURRED
While
at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Merrill M. Cross

DATE SIGNED

EXACT
NAME (Type)

MERRILL M. CROSS

5/10/59

22a. BURIAL, CREMATION OR
REMOVAL (Specify)

Burial

22b. DATE THEREOF
5-12-59

22c. NAME OF CEMETERY OR CREMATORIUM
Parklawn Cemetery

22d. LOCATION (City, town, or county)
Rockville, Md.

(State)

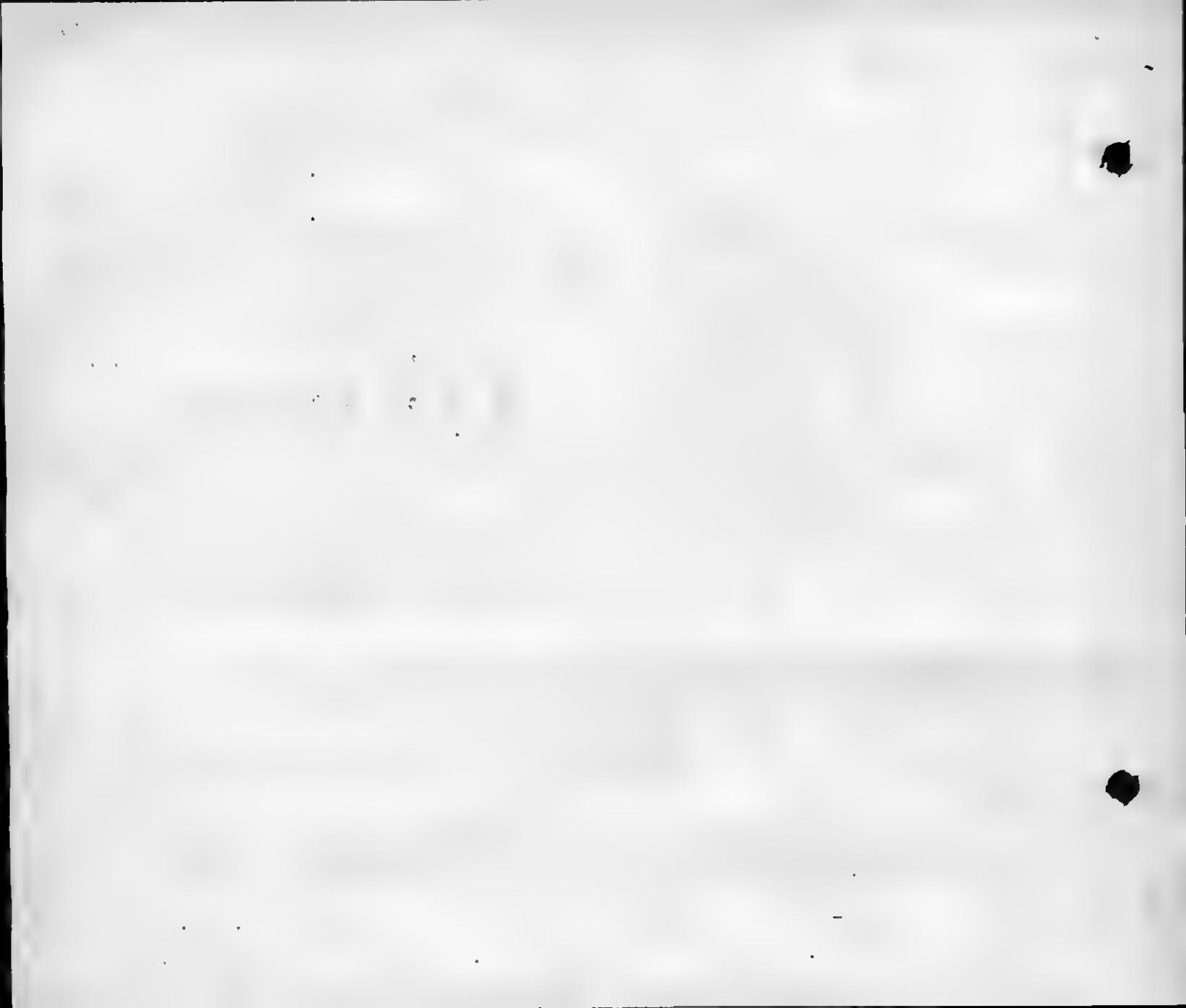
23. FUNERAL DIRECTOR'S SIGNATURE

ROBERT A. PUMPHREY, Bethesda, Md.

ADDRESS

24a. REC'D BY REGISTRAR
DATE MAY 12 '59

24b. REGISTRAR'S SIGNATURE
Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05774

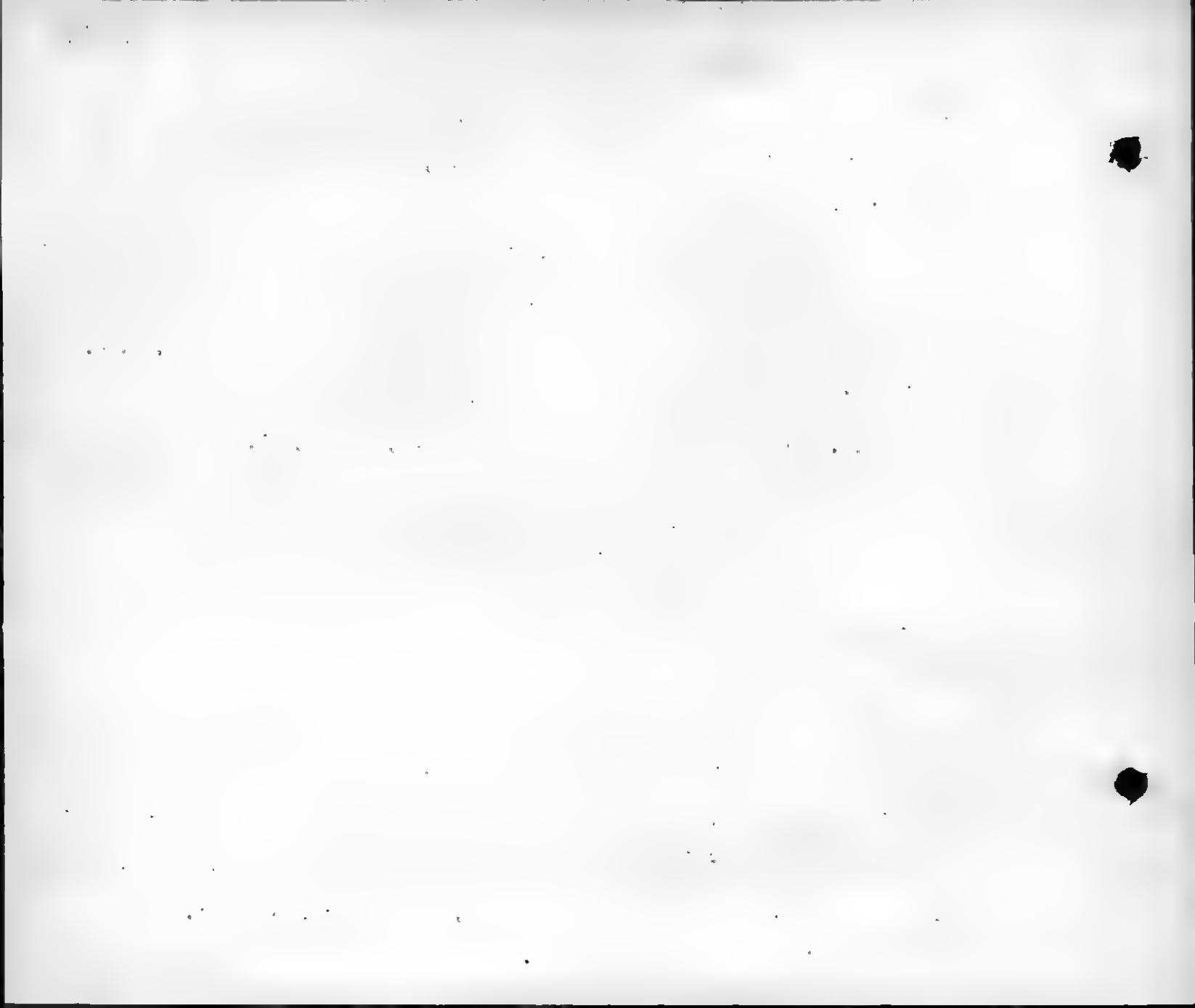
5790

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg (Rural)		c. LENGTH OF STAY IN 1b 2 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ashton,		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammons Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED [Type or print]	First Joseph	Middle W	Last Johnson	4. DATE OF DEATH	Month May	Day 18	Year 1959
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1879	9. AGE (In years less birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph H. Johnson				14. MOTHER'S MAIDEN NAME Emma Ann Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. W.W. # 1		INFORMANT Sarah Johnson, Ashton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Nephritis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO Infection of Chronic Nephritic Kidney							
DUE TO (b) One kidney removed.							
DUE TO (c) Nephritic Hypertension							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hemiplegia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 21, 1936, to May 18, 1959, that I last saw the deceased alive on May 18, 1959, and that death occurred at 1:00 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) M.D.							
DATE SIGNED 5-20-59							
ACTUAL SIGNATURE Webster Sewell, M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/59		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National,		22d. LOCATION (City, town, or county) Arlington, Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surwood, Rockville, Md.							
ADDRESS				24a. REC'D BY REGISTRAR DATE MAY 25 '59		24b. REGISTRAR'S SIGNATURE Arthur & Krause	



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

5791 CERTIFICATE OF DEATH

Reg. Dist. No. **05775**

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 8009 Eastern Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8009 Eastern Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary A. Johnson		4. DATE OF DEATH May 3, 1959	Month Day Year Month Days Hours Min.
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/71
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Sheppard		14. MOTHER'S MAIDEN NAME Alice Hampton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Edith J. Brown same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PNEUMONIA, LEFT LUNG 5 DAYS CEREBRAL THROMBOSIS, RT 1/2 YEAR HYPERTENSIVE HEART DISEASE YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROSIS GEN - CHRONIC PYLONIOPHARIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 , to May 3 , 1959, that I last saw the deceased alive on May 3 , 1959, and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4316-147th St. NW DATE SIGNED 11-0-C.			
ACTUAL SIGNATURE Jacob C. P. Hines, M.D.			
PHYSICIAN'S NAME (Type) Jacob C. P. Hines, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/6/59	
22c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR MAY 5 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5792 CERTIFICATE OF DEATH

Reg. Dist. No. 05776

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3117 Plyers Mill Rd.				d. STREET ADDRESS 3117 Plyers Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First AGNES	Middle Joyce	Last Joyce	4. DATE OF DEATH MAY	Month 9	Day 19	Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 19, 1889		9 AGE (In years lost birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during type of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Richard O'Connor			14. MOTHER'S MAIDEN NAME Johanna Reidern						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas F. Joyce		Address Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> INTERVAL BETWEEN 420.1 ONSET AND DEATH DUE TO <u>24 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Coronary Arterio Sclerosis</u> 56 yrs DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day 19	Year 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10609 CONCORD ST	20f. (City or town) McKeesport	(County) Penn	(State) Penn
21. I certify that I attended the deceased from <u>1955</u> , 19, to <u>May 9</u> , 1959, that I last saw the deceased alive on <u>May 9</u> , 1959, and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Robert T. Thibault, M.D.</u> DATE SIGNED <u>May 9, 1959</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/59		22c. NAME OF CEMETERY OR CREMATORIAL St. Josephs Cem		22d. LOCATION (City, town, or county) East McKeesport, Penna			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAY 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

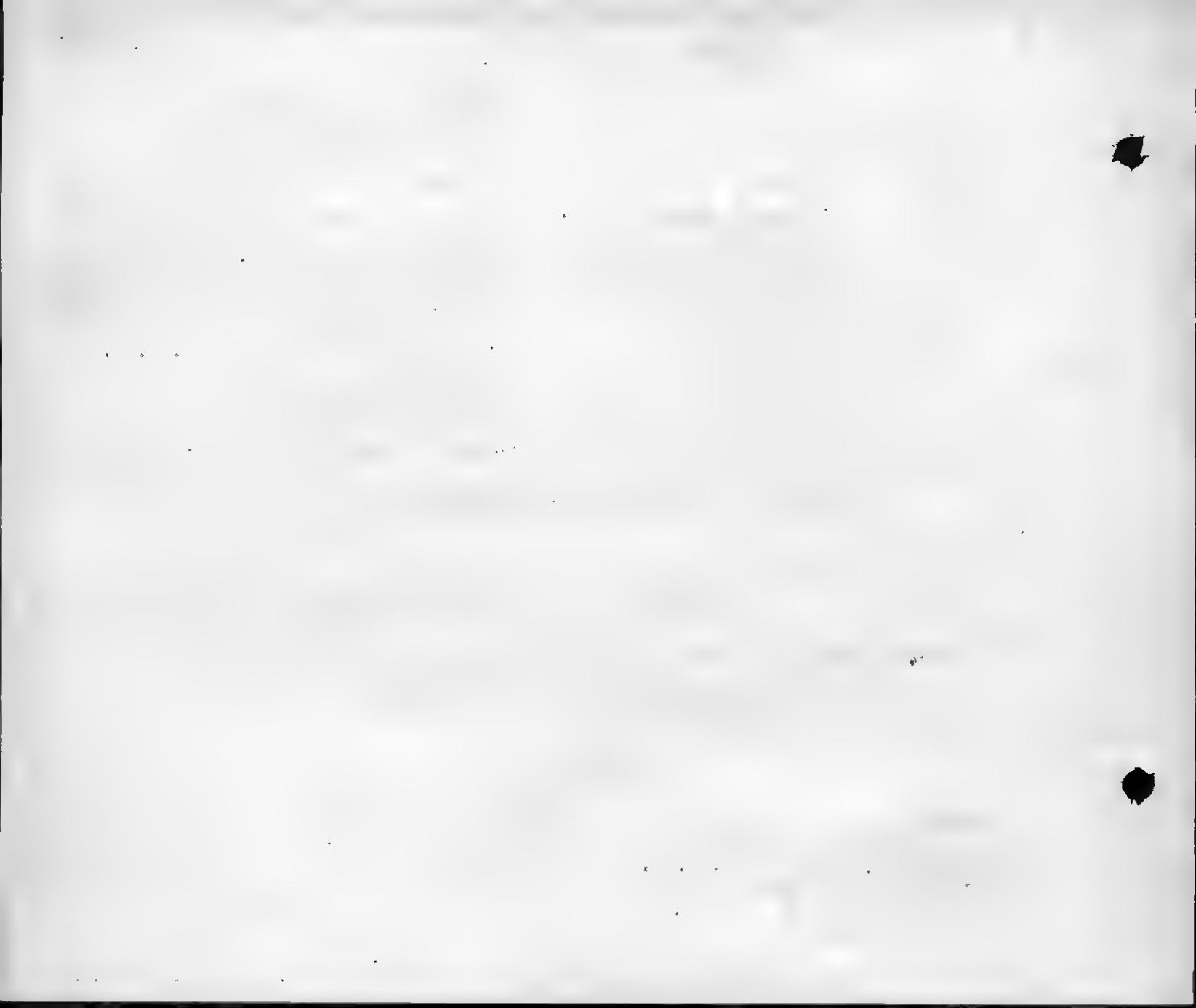
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5793 CERTIFICATE OF DEATH

105777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE New Jersey		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 199 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Passaic		d. STREET ADDRESS 201 Dayton Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Eva	Middle (none)	Last Kampelman	4. DATE OF DEATH	Month May	Day 28,	Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1888	9. AGE (In years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner		10b. KIND OF BUSINESS OR INDUSTRY Millinery		11. BIRTHPLACE (State or foreign country) Romania		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Alter Gottlieb				14. MOTHER'S MAIDEN NAME Susan Fitzer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 16.8X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 9 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cypress Hills		(County) New York (State) New York
21. I certify that I attended the deceased from November 10, 1958, to May 28, 1959, that I last saw the deceased alive on May 28, 1959, and that death occurred at 11:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center ACTUAL SIGNATURE <i>Richard Lee</i> M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) G. Richard Lee, M. D. Bethesda 14, Maryland								
22a. BURIAL, CREMATION, OR REMAINS (Specify) Burial		22b. DATE THEREOF 5-31-59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) Cypress Hills, New York (State) New York		
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons		ADDRESS 3501 14th Street, N.W.		24a. REC'D BY REGISTRAR DATE JUN 1 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

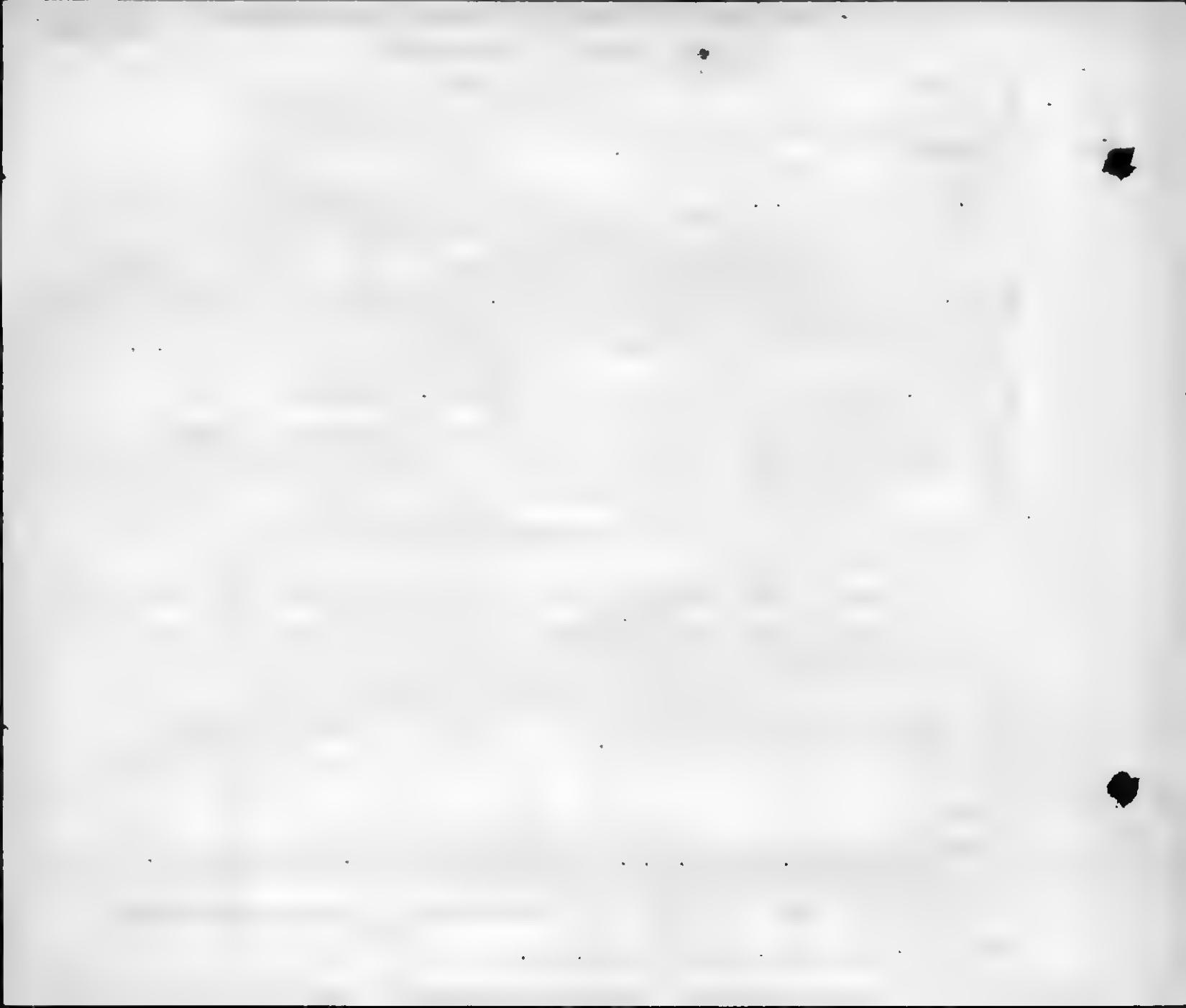
105778

5794 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5324 Pooks Hill Ct.				d. STREET ADDRESS 5324 Pooks Hill Ct.	
3. NAME OF DECEASED (Type or print) Susan Moss Kellam		First	Middle	Lost	4. DATE OF DEATH May 29,
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1875	9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Bahamas	
13. FATHER'S NAME Silas W. Moss		14. MOTHER'S MAIDEN NAME Julia G. Griffin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Dorothy Kellam-Item #2- daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary Sepsis DUE TO 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Adenocarcinoma of Urinary bladder (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 5009 Del Ray Ave., Bethesda, Md.	
20f. (City or town) 5009 Del Ray Ave., Bethesda, Md.				(County) (State)	
21. I certify that I attended the deceased from Jan. 15, 1958 , to May 29, 1959 , that I last saw the deceased alive on April 21, 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 5009 Del Ray Ave., Bethesda, Md.					
ACTUAL SIGNATURE Robert G. Angle		DATE SIGNED 5/29/59			
PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6-1-59		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	
22d. LOCATION (City, town, or county) Suitland, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		ADDRESS		24a. REC'D BY REGISTRAR JUN 2 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05779

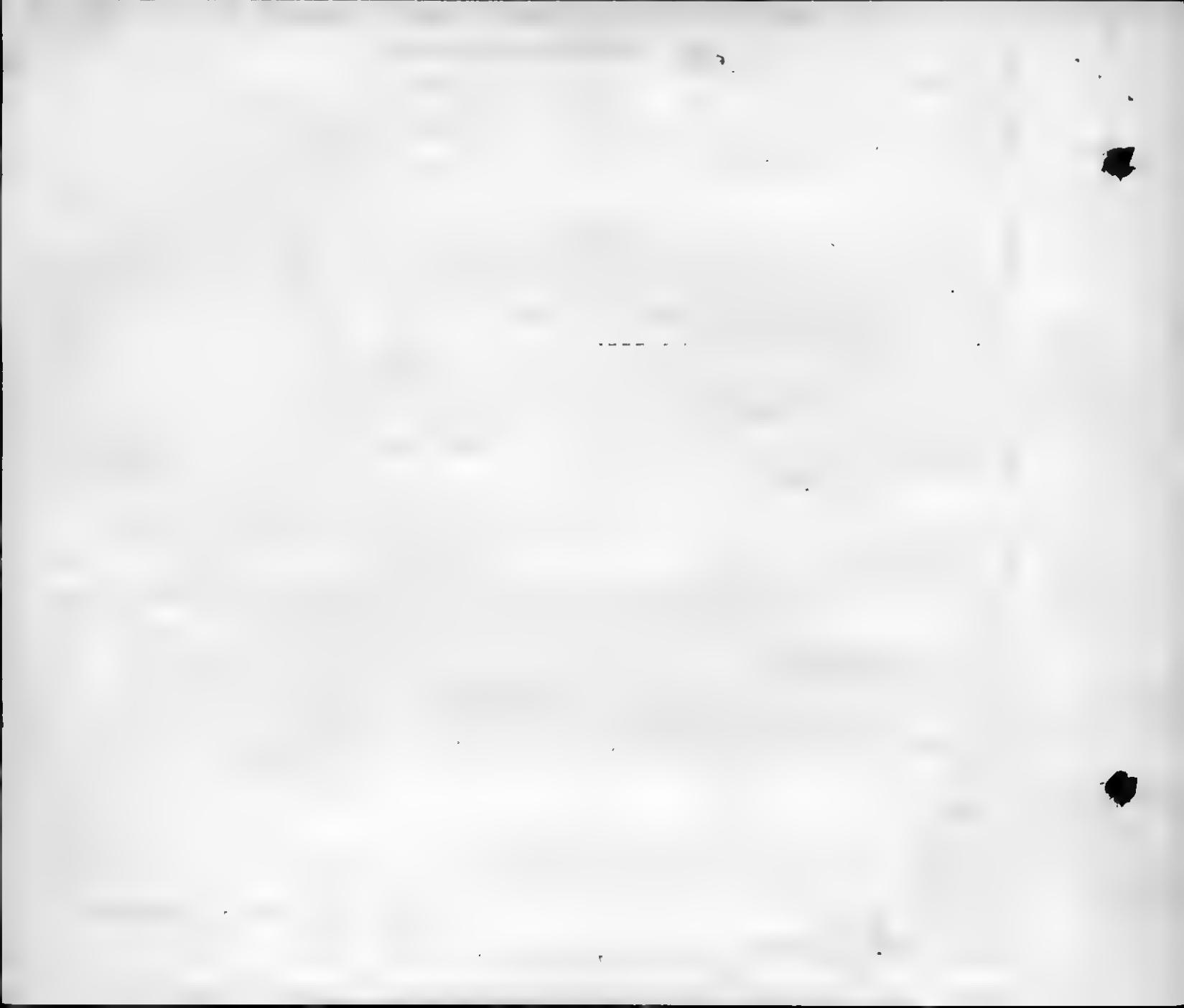
Reg. Dist. No.

5795 CERTIFICATE OF DEATH

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MARYLAND		b. COUNTY		MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		WASHINGTONTON		c. LENGTH OF STAY IN 1b		114rs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		4405 SAWL RD BETHESDA		d. STREET ADDRESS		14405 SAWL RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
FRED		CHARTERS	KELLY		May	23		1959			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years less birthday yrs.)	IF UNDER 7 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
Male		White		1/27/82	77						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
AUTHOR		-----		OHIO		U.S.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
ROBERT A. KELLY		ALICE CHARTERS									
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes or no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH			
No		410-12345678		H.W. MRS KELLY		Acute congestive heart failure				3 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)		Malnutrition + cachexia				3 mos			
		DUE TO (c)		Carcinoma of Rt Colon							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour a. m. p. m.		Month	Day	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
19											
21. I certify that I attended the deceased from <u>July</u> , 1958, to <u>May 23</u> , 1959, that I last saw the deceased alive on <u>May 19</u> , 1959, and that death occurred at <u>3:10 AM</u> , from the causes and on the date stated above.											
ADDRESS (Street, city or town, state) <u>8218 WOOD LANE, BETHESDA, MD 20814</u> DATE SIGNED <u>5/23/59</u>											
ACTUAL SIGNATURE		<u>ROBERT G. BREWER M.D.</u>									
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/23/59		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		22d. LOCATION (City, town, or county) Suitland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAY 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Turner					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File 5242 6-3-59 et

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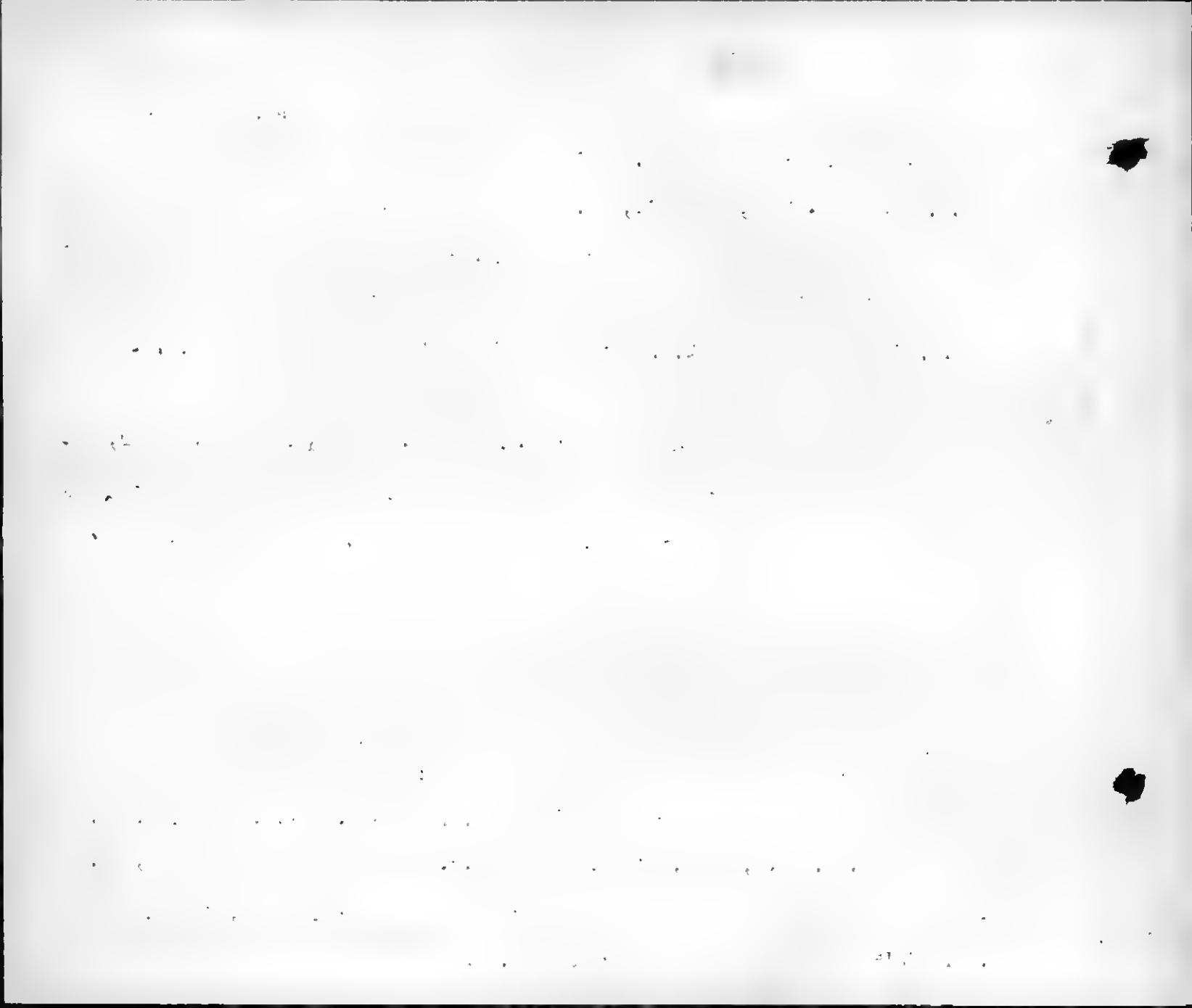
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 Mo. 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glassmanor		d. STREET ADDRESS 406 Maury Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Roy	Middle Cecil	Last Kesler	4. DATE OF DEATH Month May	Day 26	Year 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 February 1921	9. AGE (In years lost birthday) 38 39 yrs	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Hours 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Kesler				14. MOTHER'S MAIDEN NAME Carrie Goodman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII		INFORMANT Mrs. Bertha F. Kesler (Wife)		Address Glassmanor, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) subarachnoid hemorrhage DUE TO 33 x							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) bleeding posterior communicating aneurysm DUE TO (c) 3 weeks							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-28-1959 to 5-26-1959 , that I last saw the deceased alive on 26 May 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above							
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED							
ACTUAL SIGNATURE Matthew W. Wood MD							
PHYSICIAN'S NAME (Type) M. W. WOOD, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-29-59	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National			22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE J. W. LEE'S SONS 300 4th Street, N.E., WASH., D.C.				ADDRESS J. W. Lee & Sons 300 4th St. N.E.	24a. REC'D'D BY REGISTRAR MAY 28 1959	24b. REGISTRAR'S SIGNATURE Arthur L. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05781

5797

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Virginia		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 40 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		d. STREET ADDRESS 6 825 1500 South 34th St.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First John	Middle F.	Last KIERNAN	4. DATE OF DEATH May 11 1959	Month May	Day 11	Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/20	9. AGE (In years last birthday) 39 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker		10b. KIND OF BUSINESS OR INDUSTRY International Bank		11. BIRTHPLACE (State or foreign country) New York - Bx		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Joseph Francis Kiernan		14. MOTHER'S MAIDEN NAME Madeline McGuinness		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 663-14-6903		17. INFORMANT Virginia Kiernan (wife)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe cirrhosis, acute DUE TO 5x1.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) CIRRHOsis, LIVER DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 36 hours 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) Arlington (State) Va		
21. I certify that I attended the deceased from May 10 , 1959, to May 11 , 1959, that I last saw the deceased alive on May 8 , 1959, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ADDRESS DATE SIGNED DATE SIGNED										
ACTUAL SIGNATURE Philip R. Garner		M.D.								
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 15/1959		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery		22d. LOCATION (City, town, or county) Arlington Va				
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. Murphy - Arlington, Va		ADDRESS		24a. REC'D BY REGISTRAR Philip R. Garner		24b. REGISTRAR'S SIGNATURE Philip R. Garner				
				DATE MAY 13 1959						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5795 CERTIFICATE OF DEATH

Reg. Dist. No.

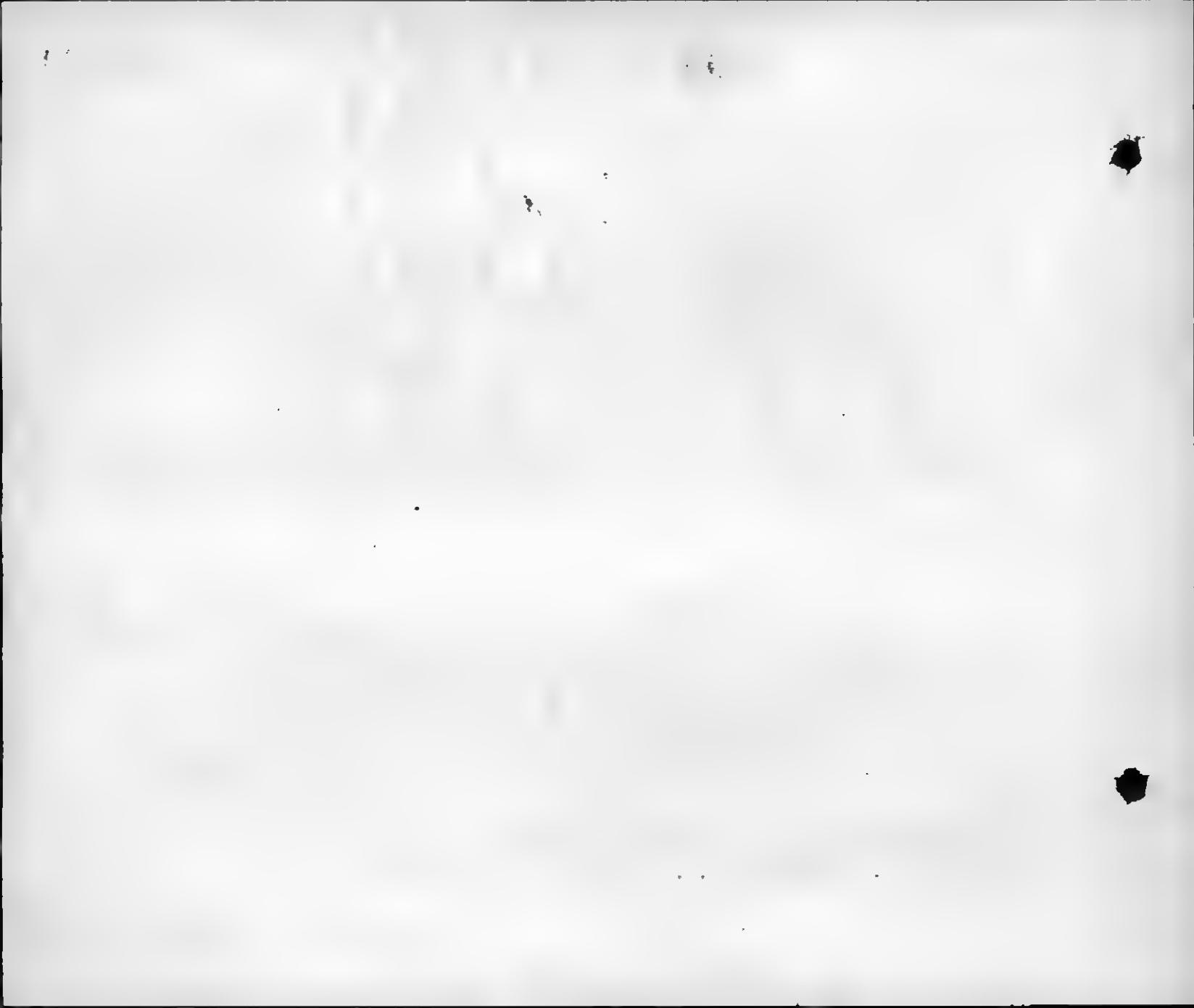
05782

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 36 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William		First	Middle	Lost	4. DATE OF DEATH Kost	Month May	Doy 15	Year 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-1884	9. AGE (In years lost birthday) 74 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seller		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Kost		14. MOTHER'S MAIDEN NAME Emmie Krey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 577-07-4068		17. INFORMANT Hospital Record, Olney, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sub-Arachnoid Hemorrhage		DUE TO				36 hours		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Arteriosclerosis, Gen/		(b) DUE TO Years						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Gaithersburg, Md.		20f. (City or town) Gaithersburg, Md.		(County) Montgomery
								(State) Md.
21. I certify that I attended the deceased from MAY 9, 1959 to MAY 15, 1959 that I last saw the deceased alive on MAY 15, 1959 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 105 Russell Ave.		DATE SIGNED 5/16/59		
ACTUAL SIGNATURE Jack Schumacher, M.D.								
NAME (Type) J. Schumacher, M.D.				Gaithersburg, Maryland		5/16/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Freedom		22b. DATE THEREOF 5-23-59		22c. NAME OF CEMETERY OR CREMATORIAL Freedom		22d. LOCATION (City, town, or county) Gaithersburg, Md.		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Wright, Gaithersburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR Cathy L. Kraw		24b. REGISTRAR'S SIGNATURE Cathy L. Kraw		
				DATE MAY 25 '59				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

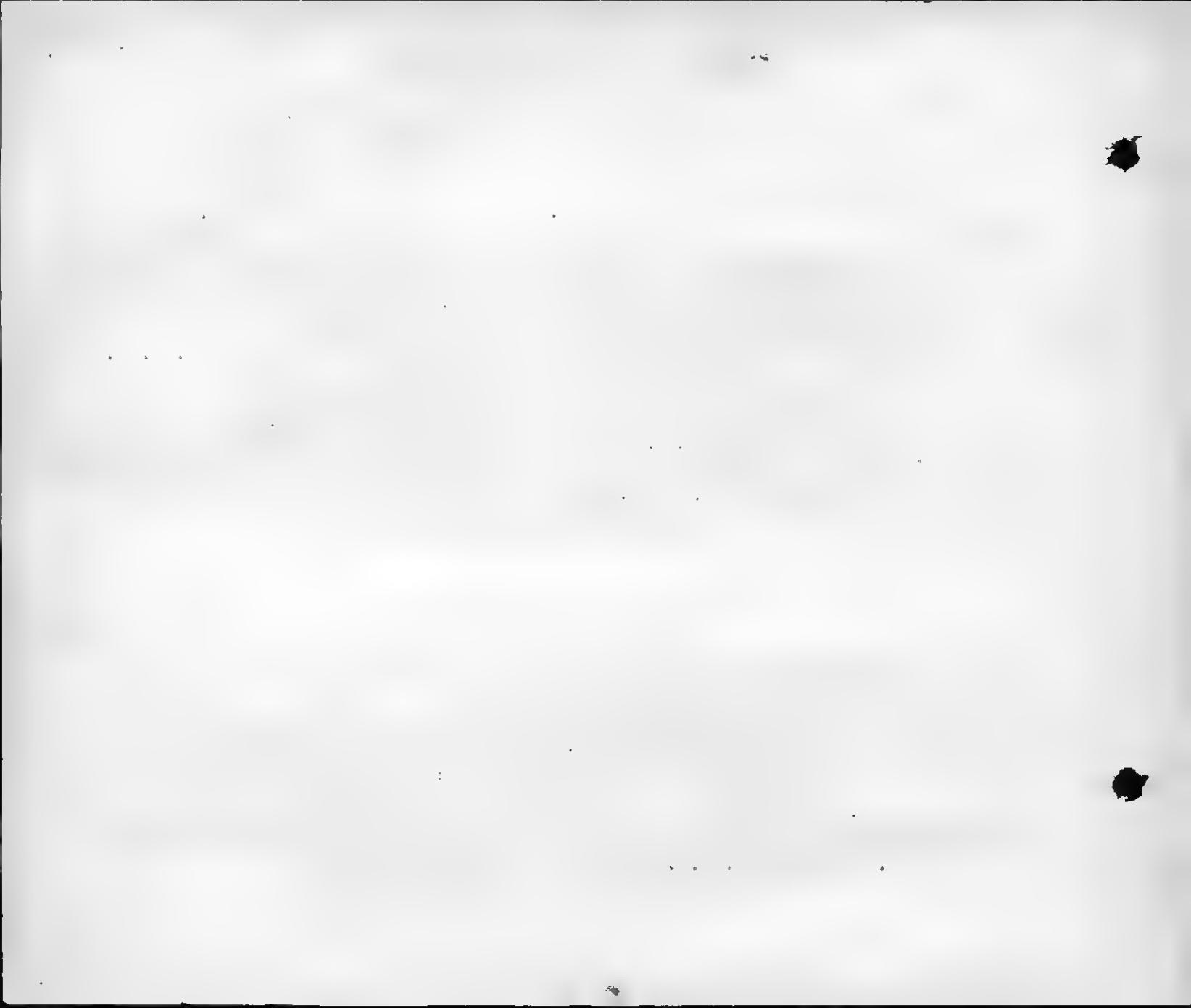
5795 CERTIFICATE OF DEATH

05783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 54 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3100 Connecticut Avenue, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Gertrude		First	Middle	Last	4. DATE OF DEATH May	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 26, 1887	9. AGE (in years last birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Theodore Ballering				14. MOTHER'S MAIDEN NAME Isabelle Wittman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO. 390-20-8845		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH days				
170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Carcinoma of the Breast Metastatic to Lung		2 Years				
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
19								
21. I certify that I attended the deceased from March 19, 1959, to May 12, 1959, that I last saw the deceased alive on May 12, 1959, and that death occurred at 3:00 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state)								
ACTUAL		<i>Richard Lee</i>		DATE SIGNED 5/12/59				
PHYSICIAN'S NAME (Type)		G. RICHARD LEE, M.D.		M.D. The Clinical Center The National Institutes of Health Bethesda 14, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-59		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet		22d. LOCATION (City, town, or county) Wash. D.C. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Timothy Naucler - 3831 - G St. AVE NW		24a. REC'D BY REGISTRAR DATE MAY 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thorne		

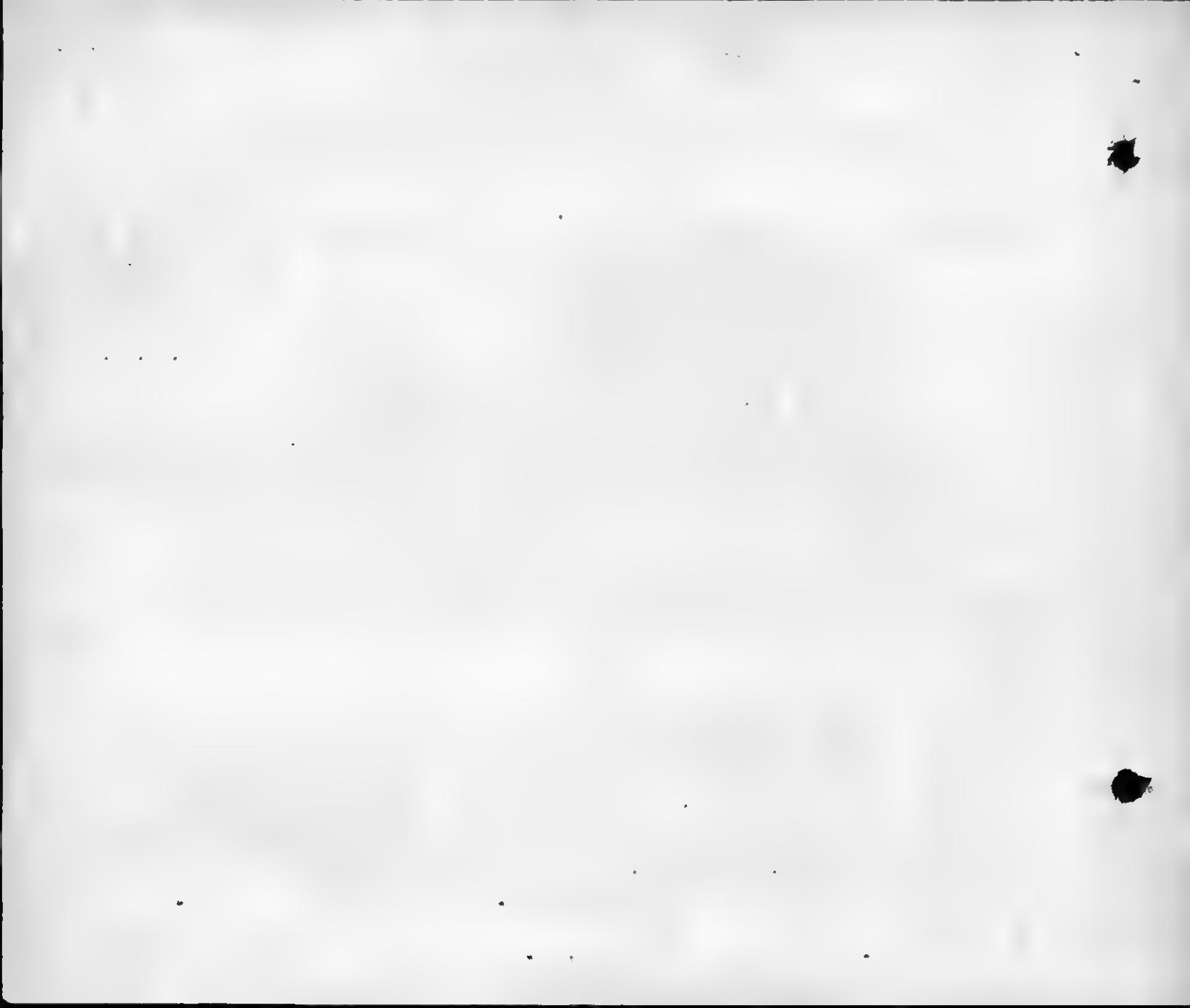
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5800 CERTIFICATE OF DEATH

Reg. Dist. No. **105784**

1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Tennessee b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb 17 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Erwin ✓					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS Willow Street Extended			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert William Lawson, Jr.			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice-President		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY U. S. A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice-President	10b. KIND OF BUSINESS OR INDUSTRY Manufacturing	11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME Robert W. Lawson, Sr.	14. MOTHER'S MAIDEN NAME Lettie Brown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) Yes <input checked="" type="checkbox"/> WW II			16. SOCIAL SECURITY NO.			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Malignant melanoma & metastasis DUE TO (c) to brain, adrenal gland			INTERVAL BETWEEN ONSET AND DEATH hours								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from May 5 , 1959, to May 22 , 1959, that I last saw the deceased alive on May 22 , 1959, and that death occurred at 10:10PM , from the causes and on the date stated above.									ADDRESS (Street, city or town, state)	DATE SIGNED	
ACTUAL SIGNATURE James M. Marsh			M.D. The Clinical Center The National Institutes of Health Bethesda 14, Maryland						5-23-59		
PHYSICIAN'S NAME (Type) JAMES M. MARSH, M.D.			22c. NAME OF CEMETERY Evergreen						22d. CITY, TOWN, STATE Tenn. (State)		
22a. BURIAL, CREMATION, ETC. (If any) Burial 5/27/59			22e. REG'D BY REGISTRAR ETWIN DATE MAY 27 '59						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Md.			24c. REC'D BY REGISTRAR DATE MAY 27 '59					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5801 CERTIFICATE OF DEATH

Reg. Dist. No.

05785

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE [Where deceased lived if institution Residence before admission] a. STATE Virginia		b. COUNTY Tazewell		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jewell Ridge		d. STREET ADDRESS (none)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Nancy		First Lee	Middle Layne	Last	4. DATE OF DEATH May 10, 1959	Month May	Day 10	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 15, 1948	9. AGE (In years last birthday) 10 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Arlin Layne		14. MOTHER'S MAIDEN NAME Lola Browning						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.2		DUE TO Cardiac Arrest.				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause first.		(b) DUE TO Pulmonary Hypertension.						
(c) DUE TO Congenital Heart Disease with Ventricular Septal Defect, Post-Operative.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from April 25, 1959, to May 10, 1959, that I last saw the deceased alive on May 10, 1959, and that death occurred at 6:45 PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>William P. Cornell</i>		M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 5/11/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/12/59		22c. NAME OF CEMETERY OR CREMATORIAL ---		22d. LOCATION (City, town, or county) (State) Man, West Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.		ADDRESS Wash. D.C. The S.H. Hines Co. - 2901 14th St., N.W.		24a. REC'D BY REGISTRAR DATE MAY 12 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thorne</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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1
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2
2

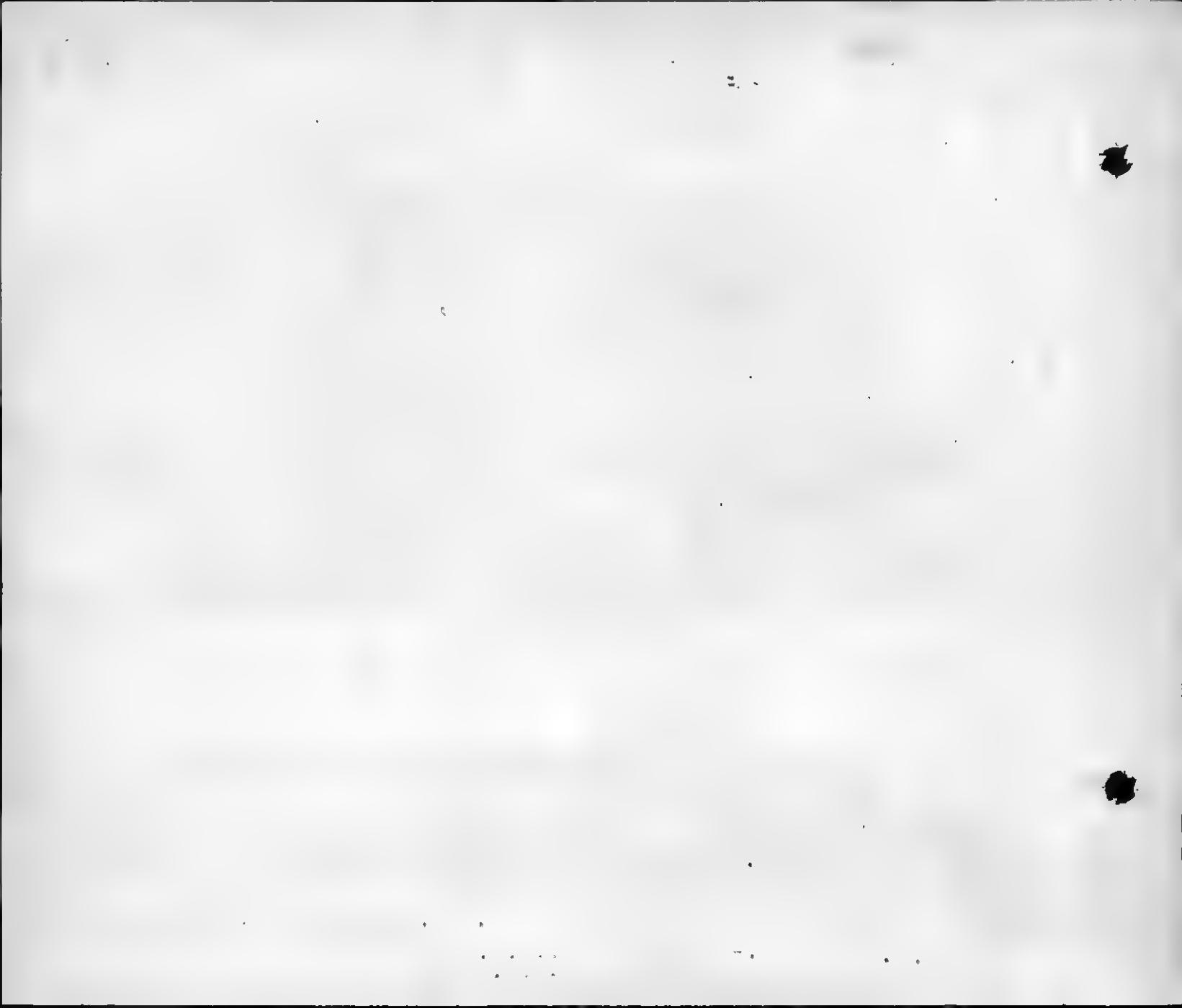
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5716

05786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson Park</i>	c. LENGTH OF STAY IN 1b <i>20 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium & Hospital</i>	d. STREET ADDRESS <i>909 McGahey Ave.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>John Gordon Lee</i>	First Middle Last	4. DATE OF DEATH <i>5 - 9 1959</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 7, 1902</i>	9. AGE (In years less than birthday) <i>56 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>	12. IF UNDER 24 HRS Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chief of Surgery Mt. Alto Hosp.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mt. Alto Hosp.</i>		11. BIRTHPLACE (State or foreign country) <i>Canada</i>			
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>			
16. SOCIAL SECURITY NO <i>WW II</i>		17. INFORMANT <i>Hospital Record</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypocardial infarction</i> <i>Coronary occlusion</i>				20. INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>		22. ACTUAL SIGNATURE <i>Merrill M. Cross</i>	
21. EXAMINER'S NAME (Type) <i>Merrill M. Cross</i>		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		23. BURIAL CREMATION REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>5/12/59</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington Natl. Cen.</i>		22d. LOCATION (City, town, or county) <i>Arlington, Virginia</i>		23b. DATE <i>MAY 11 '59</i>	
23c. ADDRESS <i>2901 14th St. N.W. Washington 9, D.C.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Krause</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		23d. (State) <i>Virginia</i>	



Patient had been receiving treatment in the Out-Patient Department of the Clinical Center of the National Institutes of Health, Bethesda 14, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

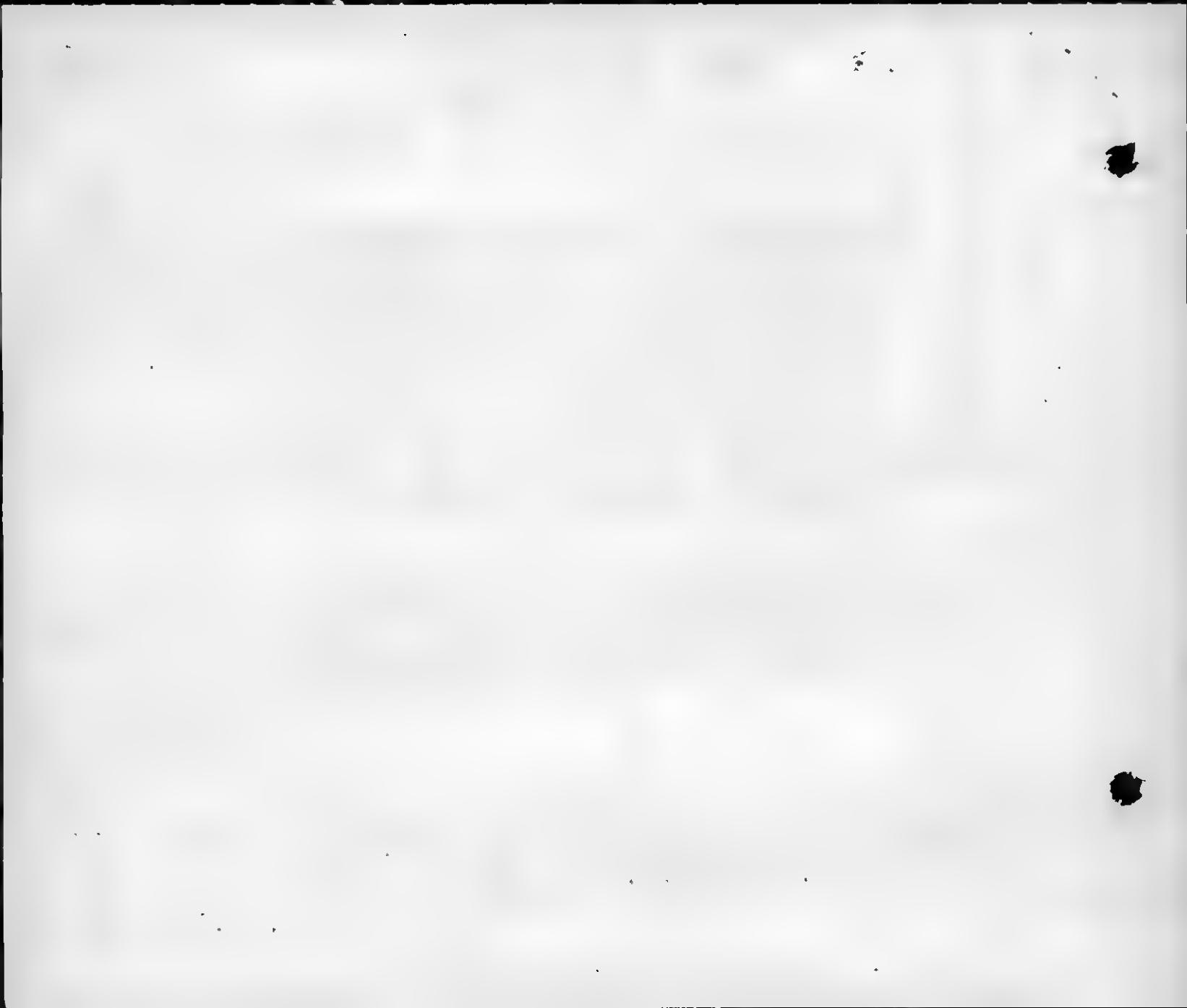
5802

CERTIFICATE OF DEATH

Reg. Dist. No.

05787

1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE South Carolina			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 43 days			b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION X 120 Center Drive						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aynor			
						d. STREET ADDRESS No Street Address			
						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First William	Middle Patrick	Last Lewis	4. DATE OF DEATH	Month May	Day 2	Year 1959
5. SEX			6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1876	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming			11. BIRTHPLACE (State or foreign country) South Carolina			12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME Daniel Lewis			14. MOTHER'S MAIDEN NAME Sarah Carmichael						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. Unascertainable			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			Pulmonary Emboli and Infarction						INTERVAL BETWEEN ONSET AND DEATH Days
			(b) Generalized Arteriosclerosis DUE TO						Years
			(c) Unknown						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			Arteriosclerotic Heart Disease						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 20, 1959, to May 2, 1959, that I last saw the deceased alive on May 2, 1959, and that death occurred at 4:15 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			DATE SIGNED 5-2-59
ACTUAL SIGNATURE Robert M. Farrier, M.D.			M.D. The National Institutes of Health Bethesda 14, Maryland						
PHYSICIAN'S NAME (Type) Robert M. Farrier, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 5/2/59			22b. DATE THEREOF 5/2/59			22c. NAME OF CEMETERY OR CREMATORIAL Conway, So. Carolina			22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland			ADDRESS			24a. REC'D BY REGISTRAR MAY 5 '59			24b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

105788

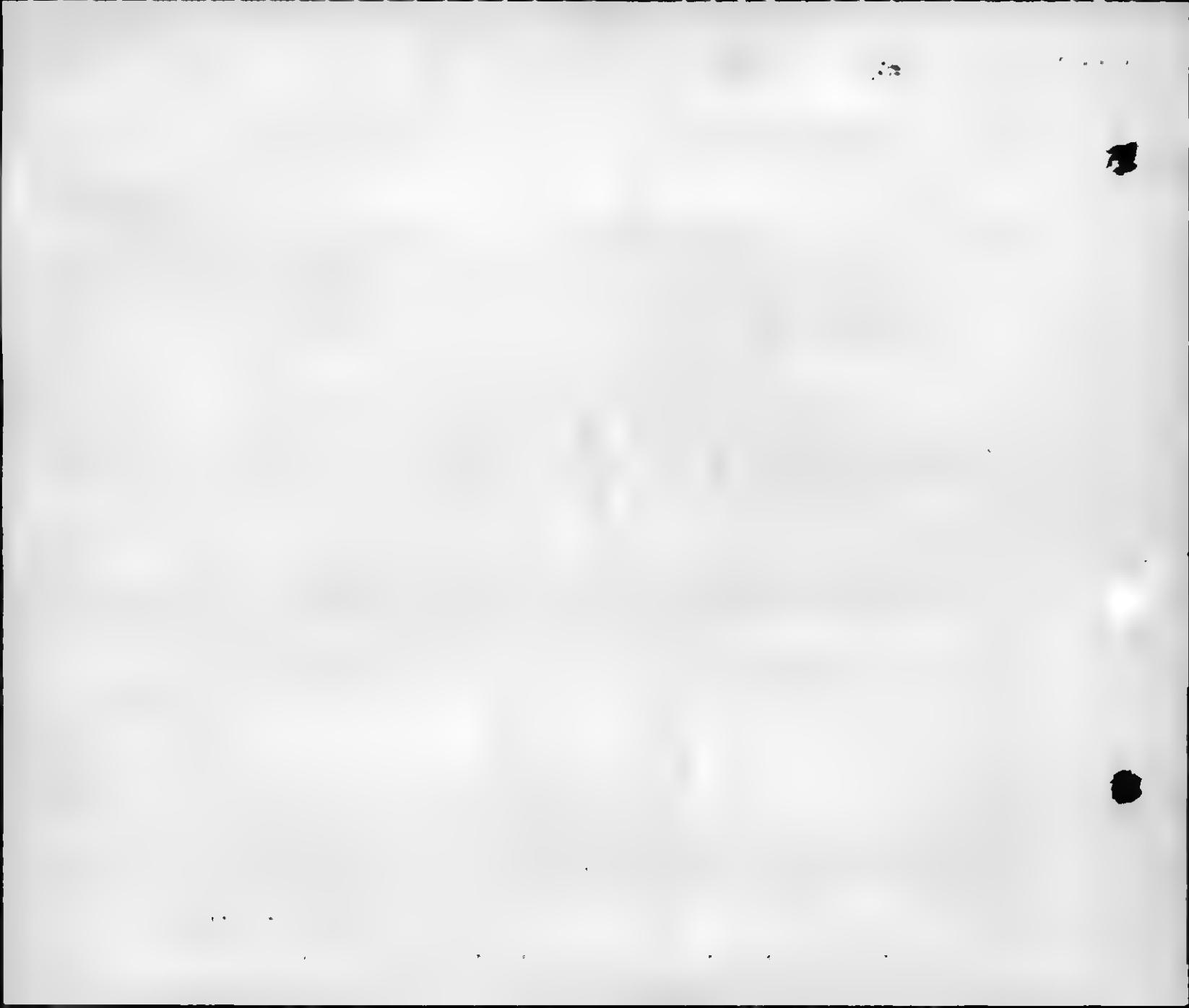
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Maryland</i>	
c. LENGTH OF STAY IN 1b <i>2 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2112 Dexter Avenue</i>		d. STREET ADDRESS <i>2112 Dexter Av.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>James F. Lightfoot</i>	First <i>James</i>	Middle <i>F.</i>	Last <i>Lightfoot</i>
4. DATE OF DEATH <i>May 21 1954</i>	Month <i>May</i>	Day <i>21</i>	Year <i>1954</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i> Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 18 1886</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>78 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Receives checks</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
10c. BIRTHPLACE (State or foreign country) <i>Texas</i>		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James W. Lightfoot</i>		14. MOTHER'S MAIDEN NAME <i>Susan Lightfoot</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>059-07-0514</i>	
17. INFORMANT <i>James F. Lightfoot</i>		Address <i>1347 Gandy Blvd., Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Brain hemorrhage</i>			
(b) <i>Brain hemorrhage</i>			
DUE TO (c) <i>Hypertension</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 21, 1954</i> to <i>May 21, 1954</i> , that I last saw the deceased alive on <i>May 21, 1954</i> , and that death occurred at <i>4:15 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1347 Gandy Blvd., Silver Spring, Md.</i> DATE SIGNED <i>May 21, 1954</i>			
ACTUAL SIGNATURE <i>Edward J. Lightfoot</i>		M.D. <i>James F. Lightfoot</i>	
PHYSICIAN'S NAME (Type) <i>Edward J. Lightfoot, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/2/59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Geo. Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR <i>John S. Krause</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Krause</i>	
DATE JUN 2 '59			



1 X
FOR STATE
HEALTH DEPT.

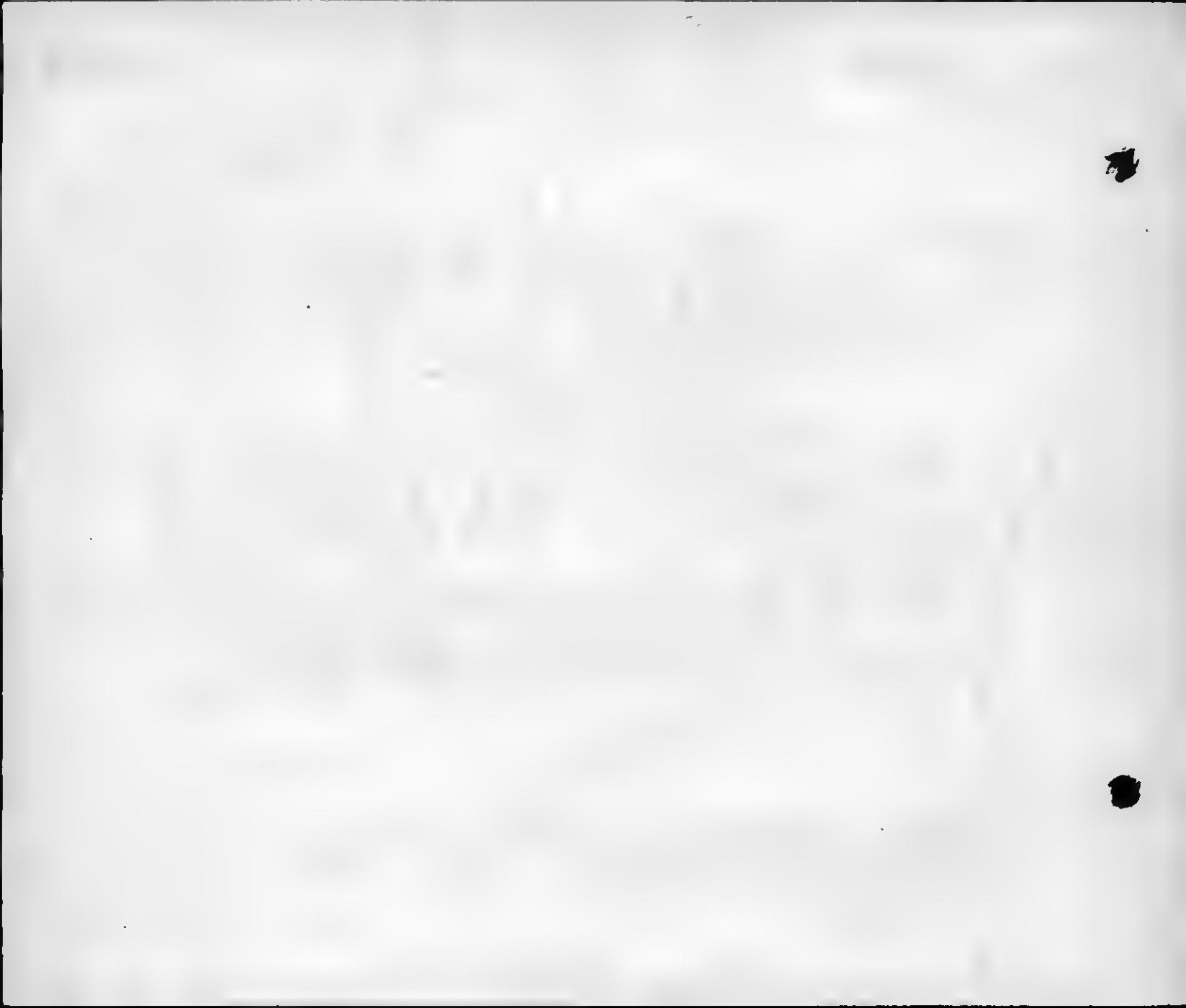
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No 15789

5805

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Md</i>	b. COUNTY <i>Montgomery</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	c. LENGTH OF STAY IN lb <i>3 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	d. STREET ADDRESS <i>3701 Cardiff Rd</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3701 Cardiff Rd</i>	1st Middle Last	4. DATE OF DEATH Month <i>May 22 1959</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Zacharias Bernard Lloyd Jr.</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-8-1914</i>	9. AGE (In years last birthday) <i>44 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <i>Dentist</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>D.C.</i>								
13. FATHER'S NAME <i>Zacharias Bernard Lloyd</i>	14. MOTHER'S MAIDEN NAME <i>Wilma Hammer</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i></i>	17. INFORMANT <i>Catherine Lloyd (wife)</i>	Address <i>1112</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary occlusion</i> <i>hypertension</i>									19. INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								20c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									DATE SIGNED <i>5-22-59</i>	
ACTUAL SIGNATURE <i>Frank J. Borschert</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) <i>FRANK J. BOSCHERT</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-25-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet</i>	22d. LOCATION (City, town, or county) <i>WASH., D.C.</i>	(State) <i></i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>JAMES T. RYAN, INC.</i>	ADDRESS <i>317 PENNA. AVENUE WASH. 3, D.C.</i>	24a. REC'D BY REGISTRAR <i></i>	24b. REGISTRAR'S SIGNATURE <i>Arthur & Kline</i>	DATE <i>MAY 25 59</i>						



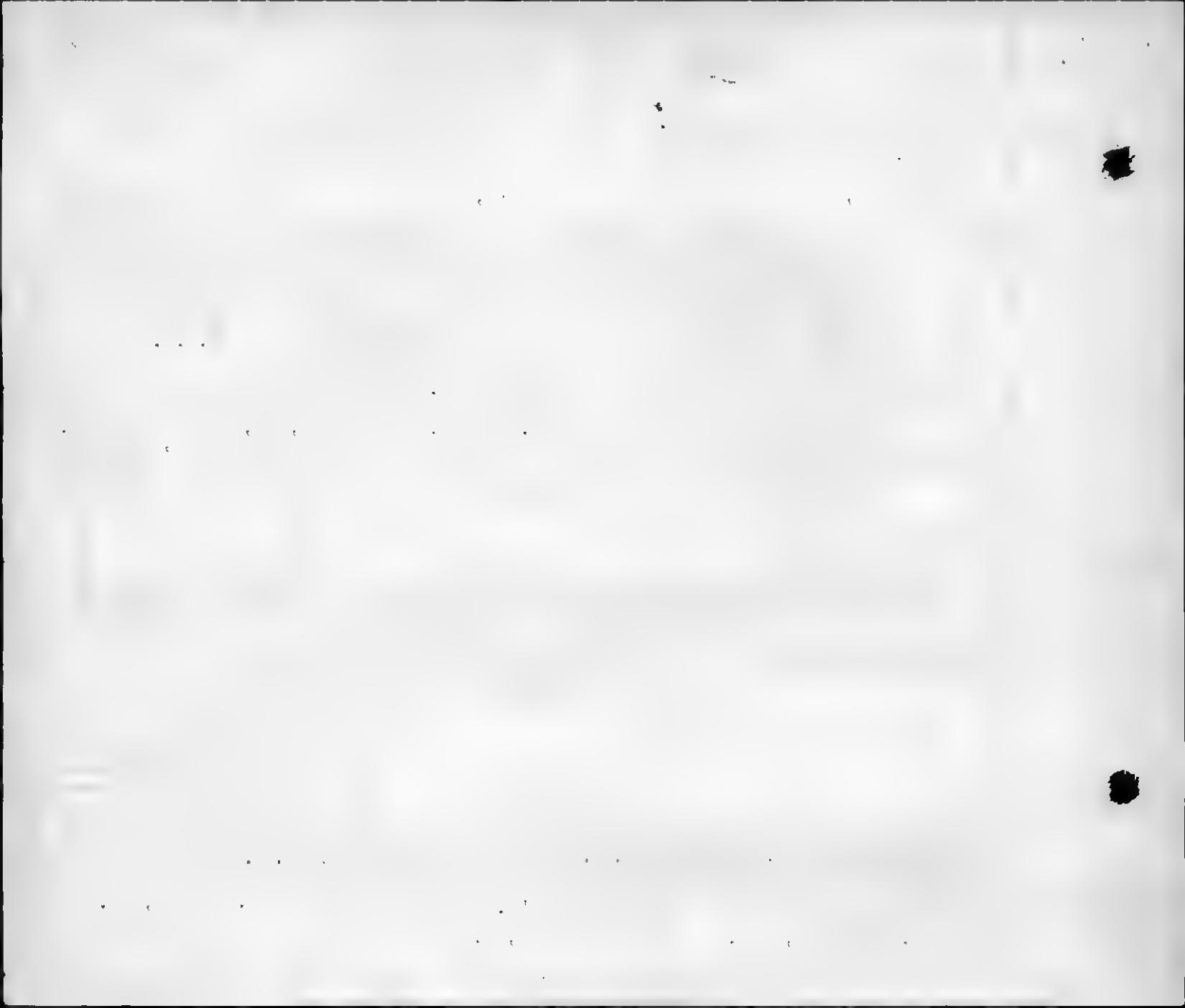
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5727 CERTIFICATE OF DEATH

05790

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN 1b 4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,715 CALDWELL STREET		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
3. NAME OF DECEASED (Type or print) EDNA		4. DATE OF DEATH MAY 1 1959	
First MIDDLE VIRGINIA		Last LOVEL	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 5/3/1900	
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Brown		14. MOTHER'S MAIDEN NAME Laura V. Barrett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary C. Van Sickler		Address 12,715 Caldwell St. Rockville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 DUE TO Lymphosarcoma		INTERVAL BETWEEN ONSET AND DEATH 5 years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 20, 1956, to May 1, 1959, that I last saw the deceased alive on April 25, 1959, and that death occurred at 6130 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 1635 Massachusetts Ave., N.W., D.C. DATE SIGNED 5/2/59	
ACTUAL SIGNATURE Harold L. Hirsh, M.D.			
PHYSICIAN'S NAME (Type)		Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/4/59	
22c. NAME OF CEMETERY OR CREMATORIUM WASHINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) Prince Geo. County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	
Raymond L. Jascha		24a. REC'D BY REGISTRAR DATE MAY 5 '59	
		24b. REGISTRAR'S SIGNATURE Clyde S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

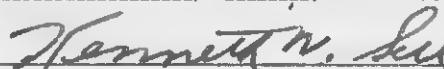
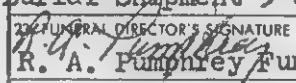
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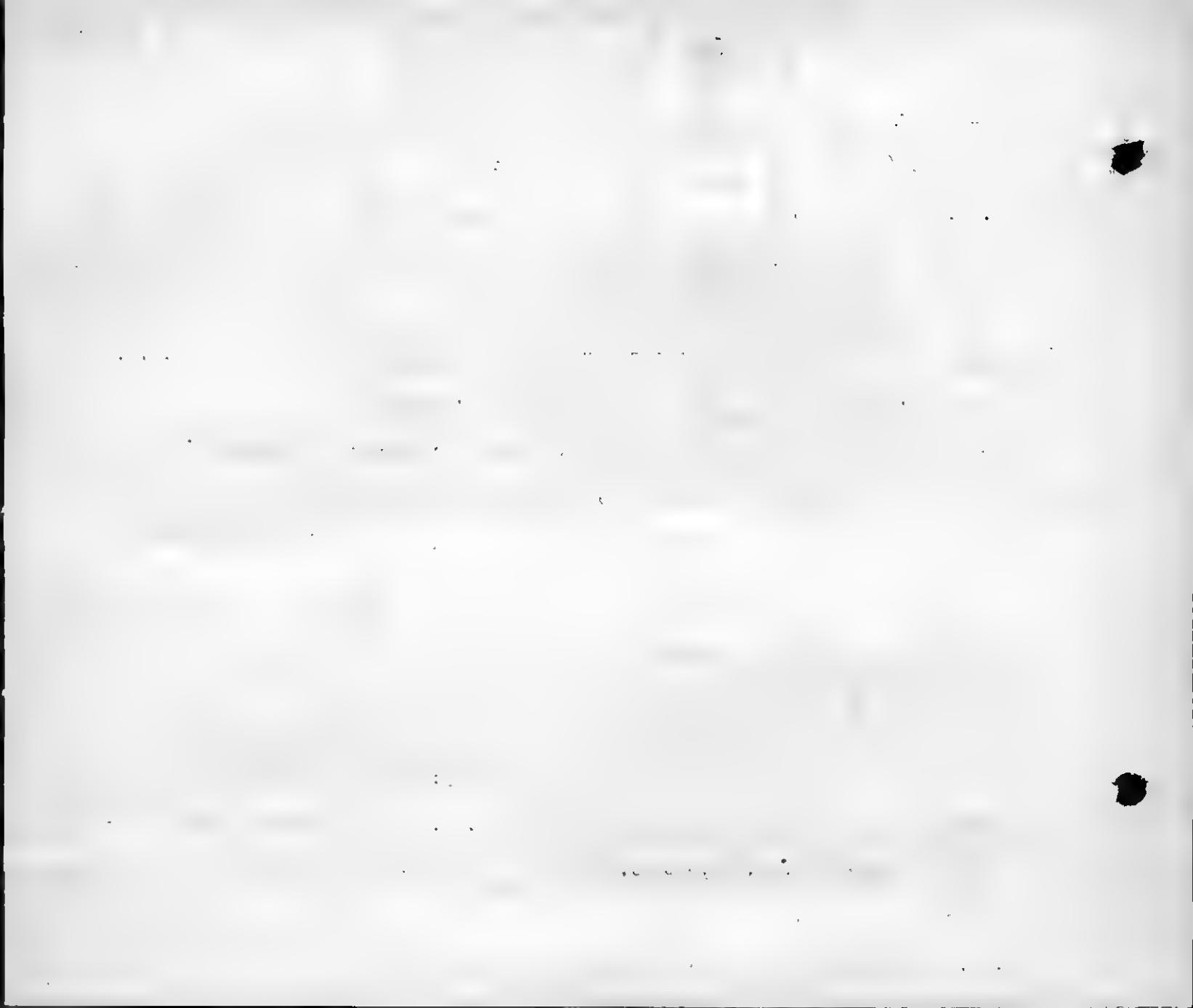
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5806 CERTIFICATE OF DEATH

05791

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Delaware		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dover		d. STREET ADDRESS 1065B 3rd Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First David	Middle ROSS	Last MADRY	4. DATE OF DEATH	Month May	Day 16	Year 1959
S. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-7-57	9. AGE (in years lost birthday) 1 yrs	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. MADRY				14. MOTHER'S MAIDEN NAME Joy D. DECELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT (F) James A. Madry, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarctions, adrenal & other organs INTERVAL BETWEEN ONSET AND DEATH							
754.2 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Congenital Heart Disease (Ventricular Septal Defect)							
DUE TO							
(c) Advanced pulmonary Hypertension							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1959 to May 16, 1959 that I last saw the deceased alive on May 16, 1959 , and that death occurred at 9:30A M , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED 5-16-59							
ACTUAL SIGNATURE 							
PHYSICIAN'S NAME (Type) Kenneth W. Sell, Lt, MC, USN							
Bethesda 14, Maryland							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial-Shipment 5-17-59		22b. DATE THEREOF 5-17-59		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) Dover (State) Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE 				24a. REC'D BY REGISTRAR Arthur S. Kincaid		24b. REGISTRAR'S SIGNATURE Arthur S. Kincaid	
R. A. Pumphrey Funeral Home, Bethesda, Md.				DATE MAY 19 '59			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5807 CERTIFICATE OF DEATH

Reg. Dist. No. **05792**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY **MONTGOMERY** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **KENSINGTON**

c. LENGTH OF STAY IN 1b **1 day**

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION **KENSINGTON GARDENS REST HOME**

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE **D.C.** b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **WASHINGTON**

d. STREET ADDRESS **1920 S Street, N.W.**

e. IS RESIDENCE ON A FARM? YES NO

3. NAME OF DECEASED (Type or print) **GATHERINE** First **CLARE** Middle **MARTIN** Last

4. DATE OF DEATH **MAY 13 1959**

5. SEX **FEMALE** **6. COLOR OR RACE** **WHITE** **7. MARRIED** **NEVER MARRIED** **8. DATE OF BIRTH** **April 9, 1885** **9. AGE (In years from birthday)** **74** **10. IF UNDER 1 YEAR** **11. IF UNDER 24 HRS.**
yrs Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Clerk-Stenographer (retired)** **10b. KIND OF BUSINESS OR INDUSTRY** **U.S. GOV'T.** **11. BIRTHPLACE (State or foreign country)** **WASHINGTON, D.C.** **12. CITIZEN OF WHAT COUNTRY?** **U.S.A.**

13. FATHER'S NAME **WILLIAM MARTIN** **14. MOTHER'S MAIDEN NAME** **MARGARET KOCH**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** **16. SOCIAL SECURITY NO.** **yes** **17. INFORMANT** **Mrs. Sarah King, Leonardtown, Maryland** **Address**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: **Bronchitis - pneumonia** **INTERVAL BETWEEN ONSET AND DEATH** **—**
IMMEDIATE CAUSE (a) **491X** DUE TO
Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last. (b) _____
DUE TO (c) _____

19. WAS AUTOPSY PERFORMED? (Yes or No) **NO**

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) **20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)**

20c. TIME OF INJURY **Month, Day, Year** **20d. INJURY OCCURRED** **20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)** **20f. (City or town)** **(County)** **(State)**
Hour o. m. **19** While **Not while** **at work** **at work**

21. I certify that I attended the deceased from **May 13, 1959** **to** **May 13, 1959** **that I last saw the deceased alive on** **May 13, 1959**, **and that death occurred at** **6:30** **M.** **from the causes and on the date stated above.**

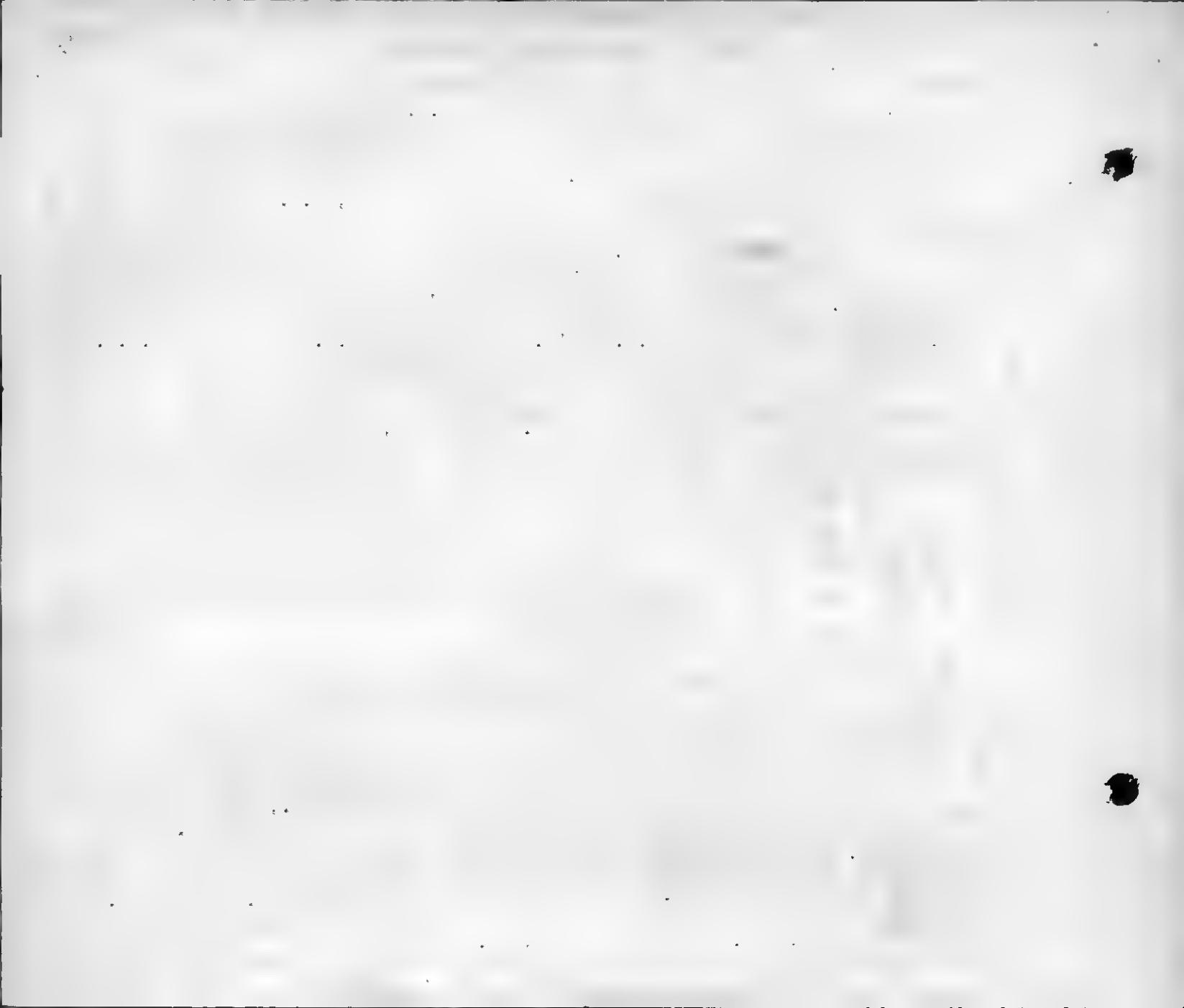
ACTUAL SIGNATURE **J. MARION BANKHEAD** **ADDRESS (Street, city or town, state)** **9241 Columbia Blvd., Silver Spring, Md.** **DATE SIGNED**

PHYSICIAN'S NAME (Type) **J. MARION BANKHEAD**

22a. BURIAL, CREMATION, REMOVAL (Specify) **CREMATION** **22b. DATE THEREOF** **5/16/59** **22c. NAME OF CEMETERY OR CREMATORIAL** **FT. LINCOLN CREMATORIAL** **22d. LOCATION (City, town, or county)** **(State)** **PRINCE GEO. COUNTY, MD.**

23. FUNERAL DIRECTOR'S SIGNATURE **WARNER E. PUMPHREY, INC.** **ADDRESS** **SILVER SPRING, MD.** **24a. REC'D BY REGISTRAR** **DATE** **MAY 18 '59** **24b. REGISTRAR'S SIGNATURE** **Arthur E. Kraus**

VS A15 (4)
15M 9/35



FOR STATE HEALTH DEPT.

If any delay is necessary, please call 3 to the funeral director. Page **[REDACTED]** may be retained for files, until the State Board of Health orders otherwise after death.

AL EXAMINER: This certificate should be executed within 24 hours after death, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PN3. Page 5 must be used as a burial-transit permit. File pages 1 and 2, item 18, prior to burial, cremation, or removal, and in case of removal within 24 hours.

TO DEPUTY MEDIC
execute the certifi-
& should be forw-
TO FUNERAL DIRE
or its designated
VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5808

05793

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission)	
Montgomery		b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cherry Chase		15 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
4001 Underwood St		Cherry Chase	
f. First		g. Middle	
Mayne		Landy Martin	
3. NAME OF DECEASED (Type or print)		h. Last	
Female White		i. DATE OF DEATH	
5. SEX		j. Month May	
6. COLOR OR RACE		k. Day 14	
7. MARRIED <input type="checkbox"/> EVER MARRIED <input type="checkbox"/>		l. Year 1959	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		m. DATE OF BIRTH Oct 15 1871	
10a. DUTIAL OCCUPATION (Give kind of work done during last of working life, even if retired)		n. AGE (In years for birthday) 87 yrs	
housewife		o. IF UNDER 1 YEAR Months Days Hours Min	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) La	
12. CITIZEN OF WHAT COUNTRY? n.s.a			
13. FATHER'S NAME Ernest Landry		14. MOTHER'S MAIDEN NAME Harriett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. No	
(If yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Laurette Richter	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Coronary Occlusions	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5-14-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-19-59	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Washington DC (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Don DeVol		ADDRESS 2224 - Wis. Ave	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE MAY 18 '59		Arthur S. Kline	



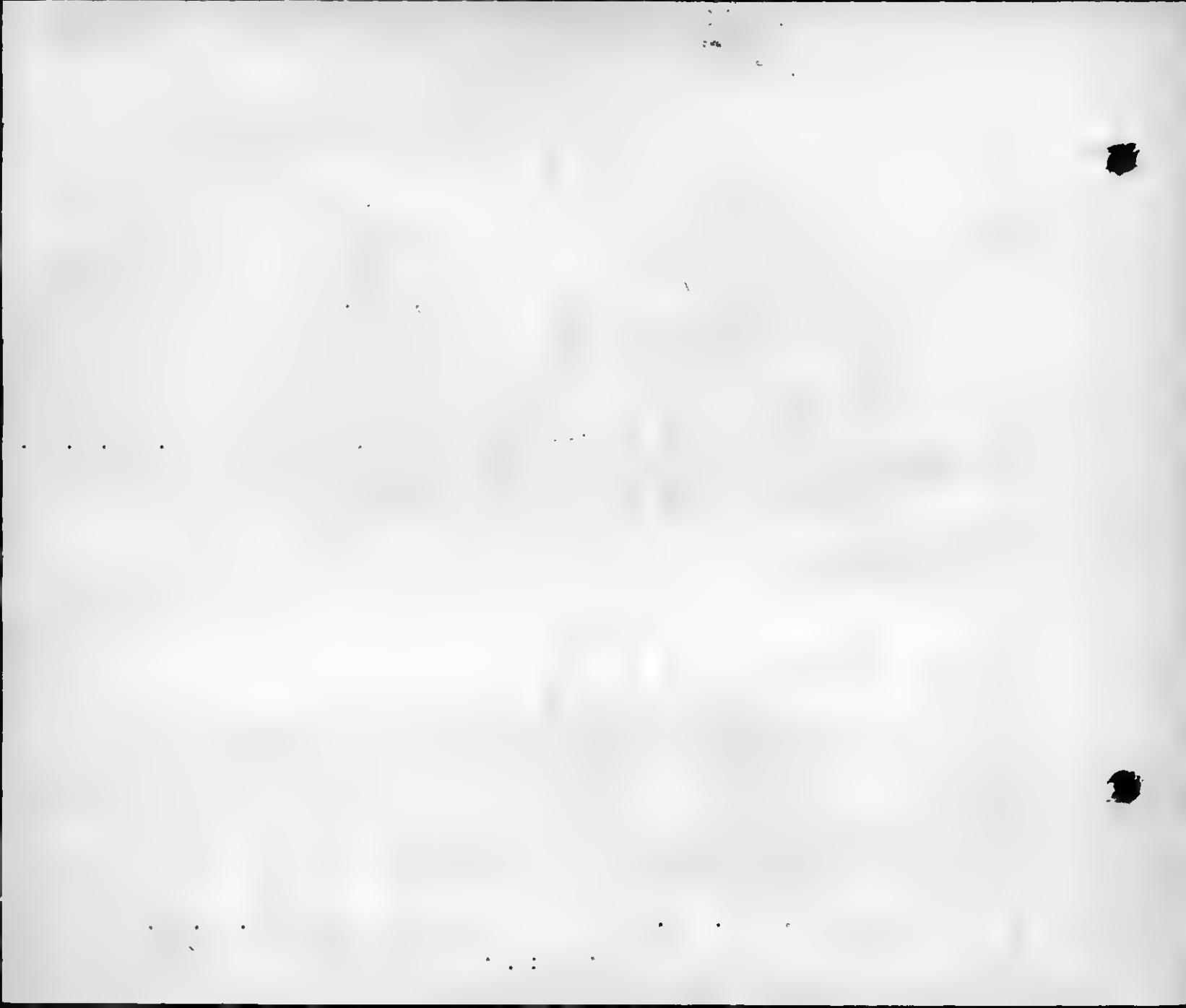
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5717 CERTIFICATE OF DEATH

05794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8507 Flower Avenue		e. STREET ADDRESS 8507 Flower Avenue	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA	First ANNA	Middle SIGNE	Last MATTSON
4. DATE OF DEATH 5	Month 5	Day 21	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 27, 1892.
			9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nils Petterson		14. MOTHER'S MAIDEN NAME Neilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Bror Walter Mattson, 8507 Flower Ave. Tak.Pk. Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 445X DUE TO <i>by persistent Cardiovascular Disease</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
p. m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 217 University Blvd E	
20f. (City or town) Silver Spring, Md.		(County) 5-21-59	
(State)			
21. I certify that I attended the deceased from Sept 5, 1955 to May 7, 1959 , that I last saw the deceased alive on May 7, 1959 , and that death occurred at 217 University Blvd E , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 217 University Blvd E			
DATE SIGNED 5-21-59			
ACTUAL SIGNATURE Bernard A Fitzgerald		M.D.	
PHYSICIAN'S NAME (Type) BERNARD A FITZGERALD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 25, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) Bladensburg Rd., Prince George Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Palley, 254 Carroll St. Tak.Pk.		24a. REC'D BY REGISTRAR Arthur S. Krause	
		24b. REGISTRAR'S SIGNATURE	
		DATE MAY 25 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05795

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Bethesda 14</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>3 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda 14</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>9120 Harrington Dr</i>		d. STREET ADDRESS <i>9120 Harrington Dr</i>	
3. NAME OF DECEASED (Type or print) <i>Reynolds Eugene McAllister</i>		4. DATE OF DEATH Month Day Year <i>May 17 1959</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>Widowed</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>6-8-1863</i>		9. AGE IN YEARS (at birthday) <i>95</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>dentist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own business</i>	
11. BIRTHPLACE (State or foreign country) <i>Maine</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Levi P. McAllister</i>		14. MOTHER'S MAIDEN NAME <i>Lorenda V. Lathrop</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Christine McAllister - Stev 2</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Brosehart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>May 17 1959</i>	
EXAMINER'S NAME (Type) <i>FRANK J. BROSEHART</i>		22b. DATE THEREOF <i>5-20-59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Highland Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Winfield, Kansas</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 19 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	
VS. A15ME 5M 2/57			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

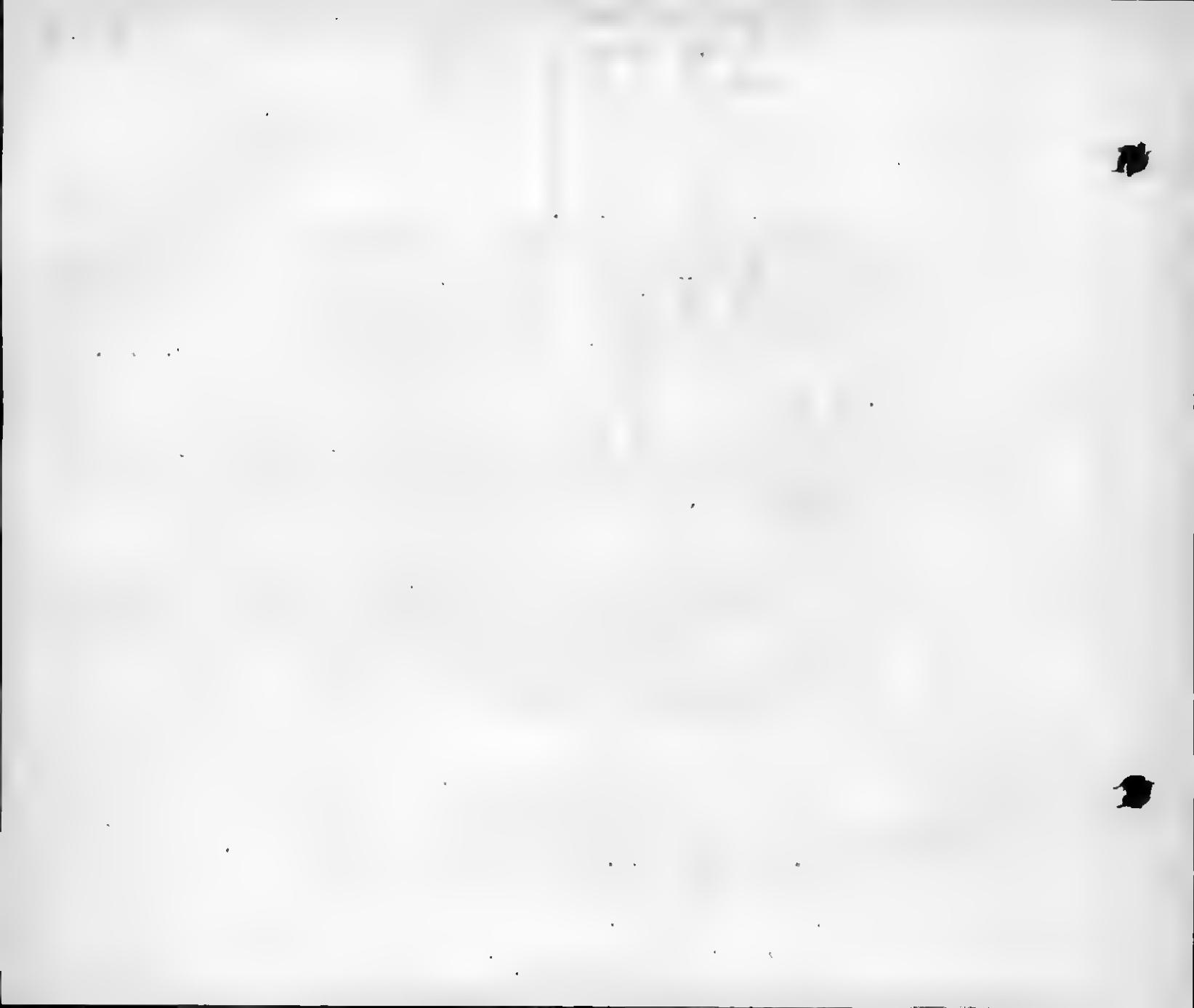
5810 CERTIFICATE OF DEATH

05796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Virginia			b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 4 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church			d. STREET ADDRESS 107 Rogers Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Herbert		Middle Leslie		Last McCeney		4. DATE OF DEATH May 24, 1959		Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1903		9. AGE (In years (at birthday) 55 yrs.)		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Photo Finishing			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME William C. McCeney						14. MOTHER'S MAIDEN NAME Carrie Dove						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO			16. SOCIAL SECURITY NO. Unavailable			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 023X			DUE TO Ventricular fibrillation			INTERVAL BETWEEN ONSET AND DEATH minutes						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)			DUE TO Myocardial infarction			days						
(c)			Aortic insufficiency, luetic			years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19												
21. I certify that I attended the deceased from May 20, 1959, to May 24, 1959, that I last saw the deceased alive on May 24, 1959, and that death occurred at 8:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5-24-59												
ACTUAL SIGNATURE Eugene B. Feigelson		M.D.										
PHYSICIAN'S NAME (Type) Eugene B. Feigelson, M.D.												
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF May 27, 1959		22c. NAME OF CEMETERY OR CREMATORIAL National Memorial Park		22d. LOCATION (City, town, or county) Fairfax County, Virginia		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE C. B. Ivey's Funeral Home, Inc.		ADDRESS 2847 Wilson Blvd. Arlington 1, Va.		24a. REC'D BY REGISTRAR DATE MAY 26 '59		24b. REGISTRAR'S SIGNATURE O. H. - 94						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. A153ME
SM 2/57

FOR STATE
HEALTH DEPT.

M

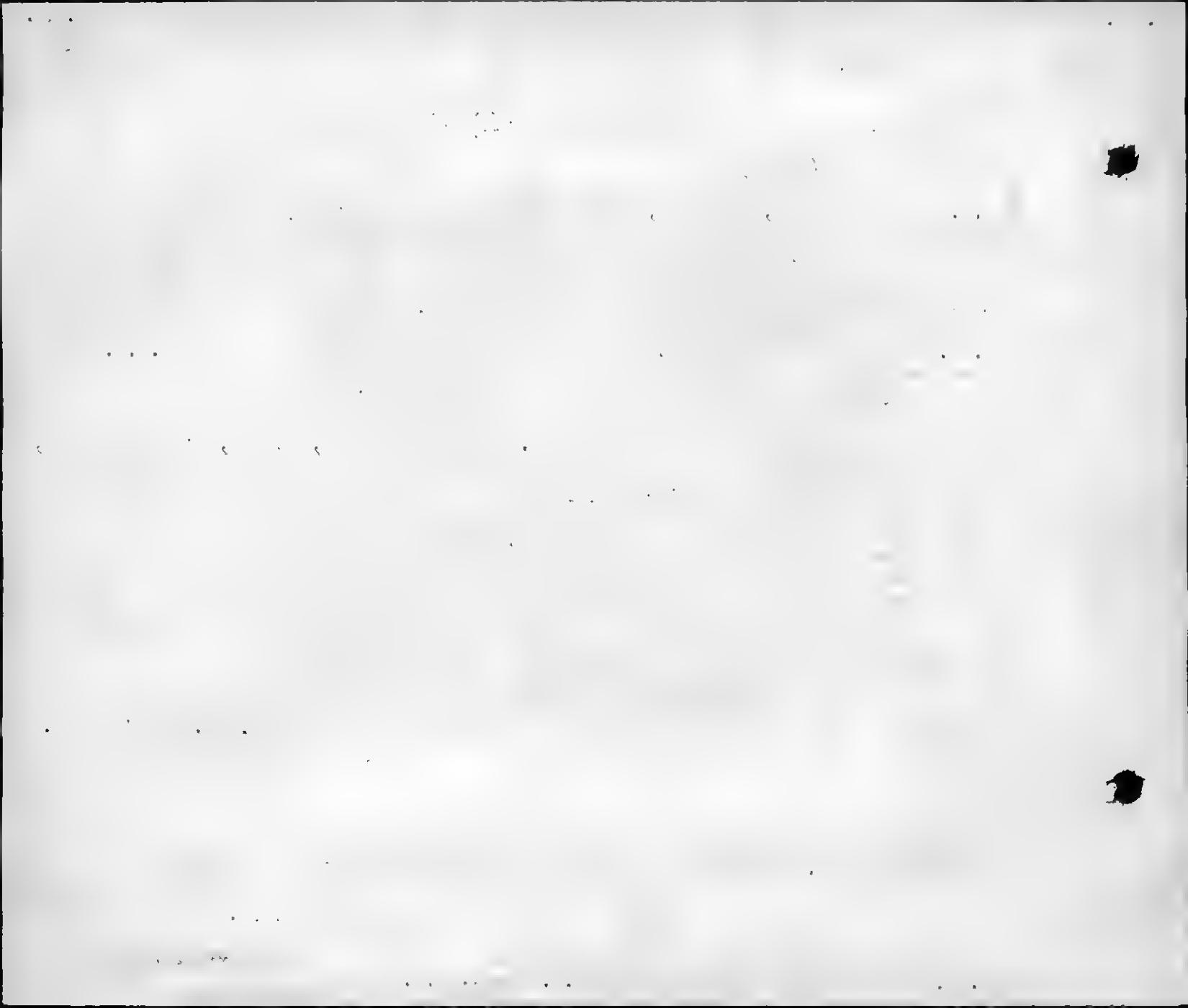
1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05797

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk		d. STREET ADDRESS 1661 Banning Road				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Forest Hope MC CLANAN		First	Middle	Lost	4. DATE OF DEATH May 22	Month	Day	Year		
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1919	9. AGE (In years from birthday) 39	10. IF UNDER 1 YEAR Months 39	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 MINS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Pilot		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Hugh Hope MC CLANAN		14. MOTHER'S MAIDEN NAME Zelpha Wolf								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Total no. or unknown) Yes		16. SOCIAL SECURITY NO 1941-1959		17. INFORMANT Wife		Address Mrs. Arlene MC CLANAN, Qtrs H, Patuxent River, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Abdominal hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 9 hours				
860X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Multiple injuries, extreme		9 hours				
		(b)		DUE TO Helicopter accident						
		(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Helicopter accident		20c. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY 1010 a.m.		Month, Day, Year May 22 1959		20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NAS PAX RIV MD		20f. (City or town) Patuxent R. St. Mary's	(County) Md.	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		EXAMINER'S NAME (Type) Frank J. Broschart		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-23-59				
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 25 May 1959		22c. NAME OF CEMETERY OR CREMATORIAL Memorial Cemetery		22d. LOCATION (City, town, or county) Norfolk, Va.				
23. FUNERAL DIRECTOR S. H. HINES COMPANY, 2901 14th St., N.W. Wash., D.C.										
						24a. REC'D BY REGISTRAR Arthur S. Hines	24b. REGISTRAR'S SIGNATURE Arthur S. Hines			
						DATE MAY 27 '59				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon-poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

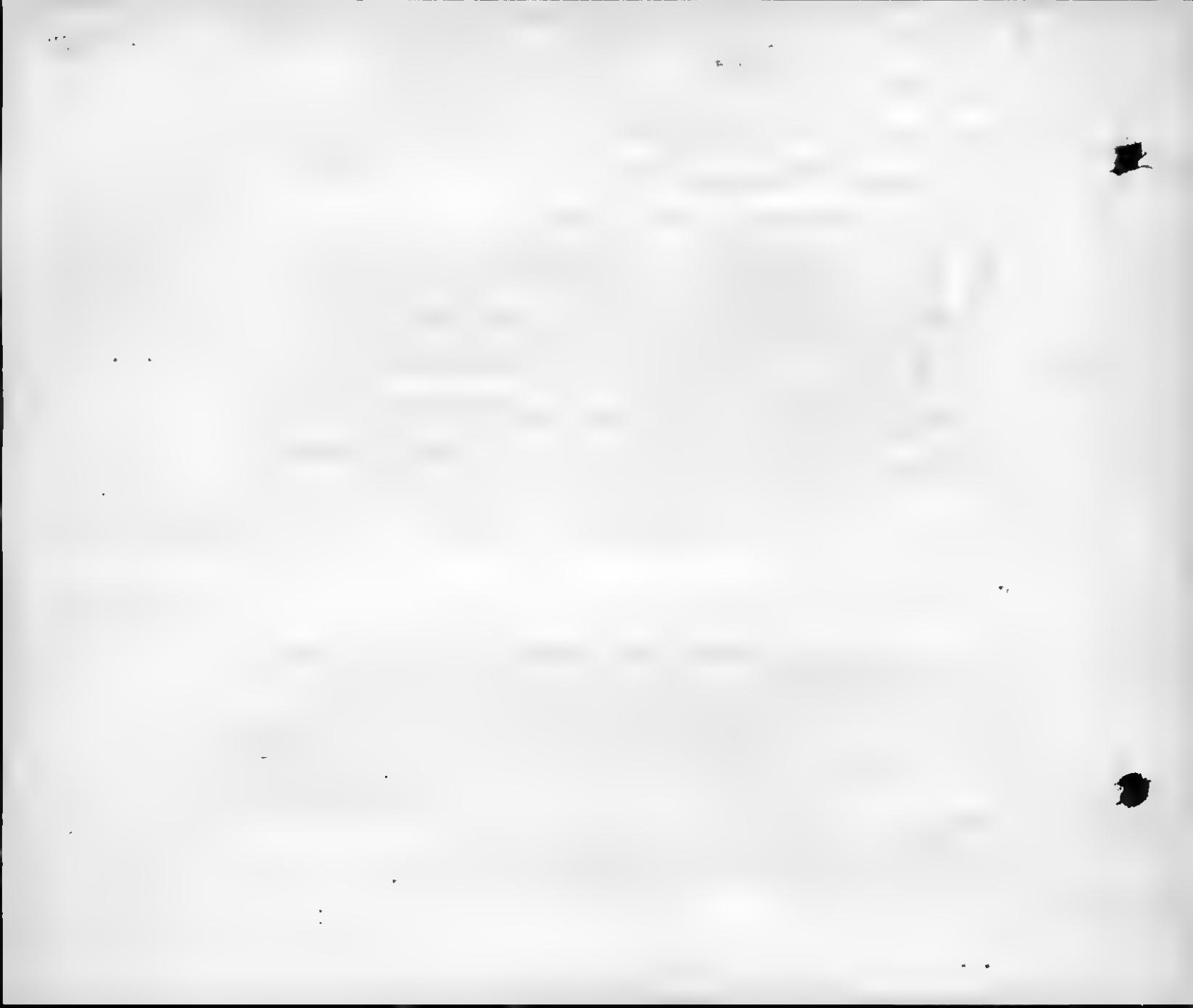
5812

CERTIFICATE OF DEATH

Reg. Dist. No.

05798

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		b. COUNTY	
c. LENGTH OF STAY IN 1b 2 days		Howard	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Ind.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Guilford	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
		John	Jeffery
3. NAME OF DECEASED (Type or print)		Lost	4. DATE OF DEATH
		McDonald	Month
5. SEX		5. COLOR OR RACE	6. DATE OF BIRTH
Male		White	May 4, 1959
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. AGE (In years last birthday) yrs.
White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
			12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Chancey McDonald		Ruby Genevieve Edwards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT
			Address
		Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		2 days	
762.5		Atelectasis	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO	
(b)		Prematurity (2# 2oz)	
DUE TO		2 days	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 4, 1959, to May 6, 1959, that I last saw the deceased alive on May 6, 1959, and that death occurred at 1:10 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE C. S. Whitaker, M. D.		DATE SIGNED May 6, 1959	
NAME (Type)		C. S. Whitaker, M. D., Clarksville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-9-59	22c. NAME OF CEMETERY OR CREMATORIAL Christ Church
		22d. LOCATION (City, town, or county) (State) Guilford Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.		24a. REC'D BY REGISTRAR DATE MAY 11 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Turner



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

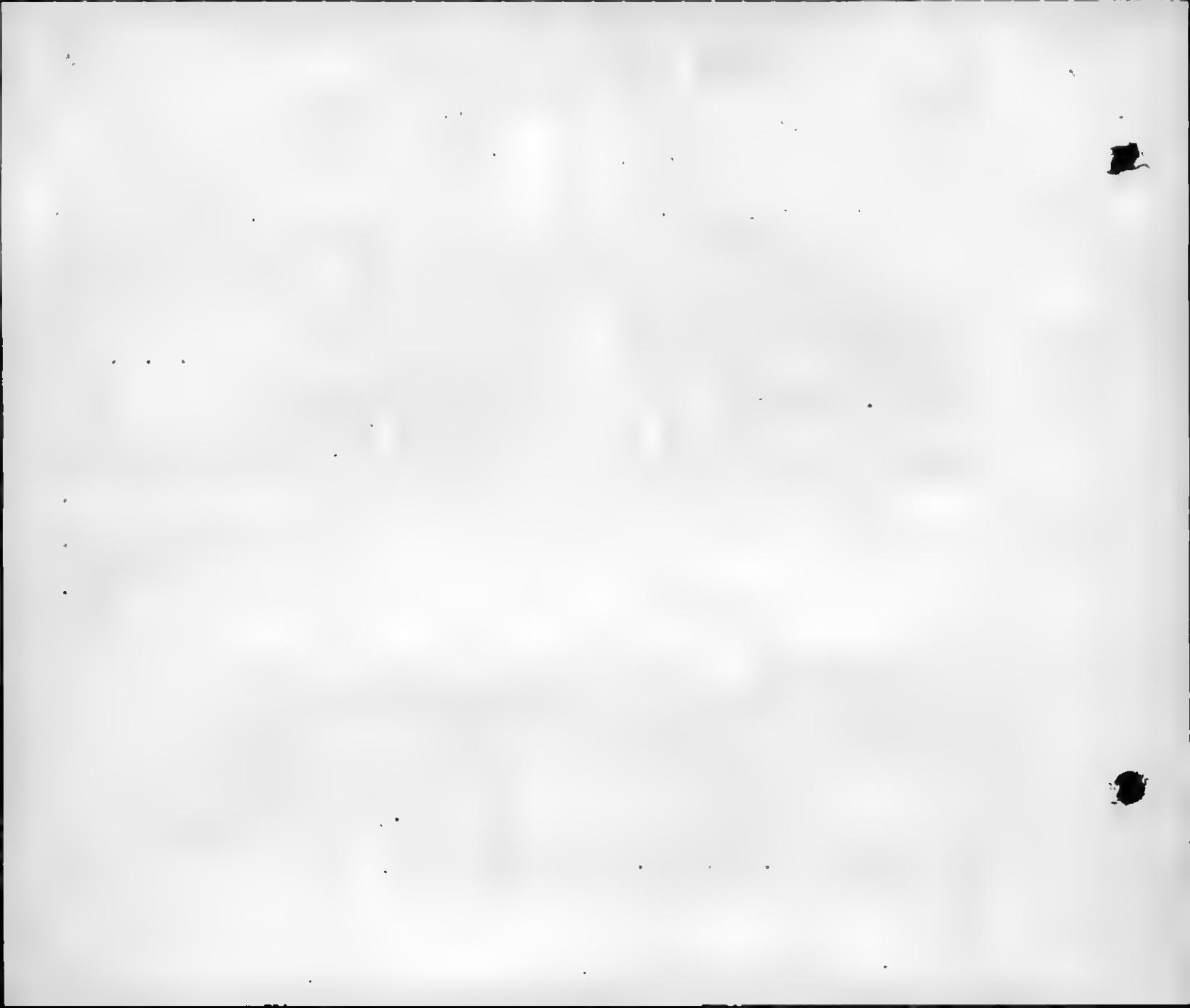
5813 CERTIFICATE OF DEATH

Reg. Dist. No.

05799

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Florida		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 129 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Smyrna Beach		d. STREET ADDRESS 616 North Orange Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Nancy	Middle Pearl	Last Melvin	4. DATE OF DEATH Month May	Month 6	Day 19	Year 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 20, 1902	9. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR Months 5		IF UNDER 24 HRS Hours 48 hrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Caswell J. Richbourg				14. MOTHER'S MAIDEN NAME Elizabeth Johnson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO 43 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Pulmonary infarcts (c) DUE TO Acute myelogenous leukemia		INTERVAL BETWEEN ONSET AND DEATH 7 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Suitland	(County) Maryland	(State) VS A15 (4)			
21. I certify that I attended the deceased from December 28, 1958 , to May 6, 1959 , that I last saw the deceased alive on May 6, 1959 , and that death occurred at 11:40 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Richard H. Moy</i> PHYSICIAN'S NAME (Type) Richard H. Moy, M. D.								ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland	DATE SIGNED May 6, 1959
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 5-7-59	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	22d. LOCATION (City, town, or county) Suitland	(State) Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.				24a. REC'D BY REGISTRAR DATE MAY 8 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5814

CERTIFICATE OF DEATH

05800

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Lanham Hills		d. STREET ADDRESS 7759 Emerson Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Earl	Middle Allison	Last MERRYMAN	4. DATE OF DEATH	Month May	Day 31	Year 1959
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3 May 1901	9. AGE (In years last birthday) 58	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Franklin Merryman		14. MOTHER'S MAIDEN NAME Maude Youngblood					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1921-1952		INFORMANT Mary Irene Merryman (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MALNUTRITION & INANITION</u> INTERVAL BETWEEN DUE TO ONSET AND DEATH 2 MONTHS							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>CARCINOMA COLON, RECURRENT, WITH</u> 6 YEARS DUE TO (c) <u>METASTASES TO PERITONEAL & PLEURAL ORGANS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. 19 p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 May 1959</u> , 19 <u>59</u> , to <u>31 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>31 May</u> , 19 <u>59</u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>F. S. Caldwell</u> M.D.							
PHYSICIAN'S NAME (Type) F. S. CALDWELL LT MC USN U. S. Naval Hospital, Bethesda, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4 June 1959		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gaech's Sons</u> ADDRESS Hyattsville, Md.							
24a. REC'D BY REGISTRAR DATE JUN 3 '59				24b. REGISTRAR'S SIGNATURE <u>Clinton S. Krause</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO
FOR
HEALTH**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or in

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5815

05801

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Montgomery

MARYLAND

2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)

b. STATE MDb. COUNTY Maryb. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda

c. LENGTH OF STAY IN lb

5 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesdad. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give general address)
6200 Verne Std. STREET ADDRESS
6200 Verne St.e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

May 31

1959

5. SEX

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

1-19-1885

9. AGE (in years
last birthday)

74 yr

10. IF UNDER 1 YEAR

Months 4 Days 12

11. IF UNDER 21 HRS.

Hours 0 Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)
Waitress

10b. KIND OF BUSINESS OR INDUSTRY

Gas

11. BIRTHPLACE (State or foreign country)

Pa

12. CITIZEN OF WHAT COUNTRY?

M.S.A.

13. FATHER'S NAME

Samuel Duncan

14. MOTHER'S MAIDEN NAME

Unknown15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

578-30-7528B

17. INFORMANT

John Miller (son)

Address

112-2

INTERVAL BETWEEN
ONSET AND DEATH

sudden

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

105.5

DUE TO

Pulmonary Thrombosis

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

Fracture rt. leg

(c)

2 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

Fall while crossing street

20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 9 am 3-21 195920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
street(County)
Washington(State)
DC21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATURE

Frank J. Brochart

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

5-31-59

22a. BURIAL, CREMATION, OR
REMOVAL (Specify)

Burial

6/3/59

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

Parklawn Cemetery

22d. LOCATION (City, town, or county)

(State)

Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

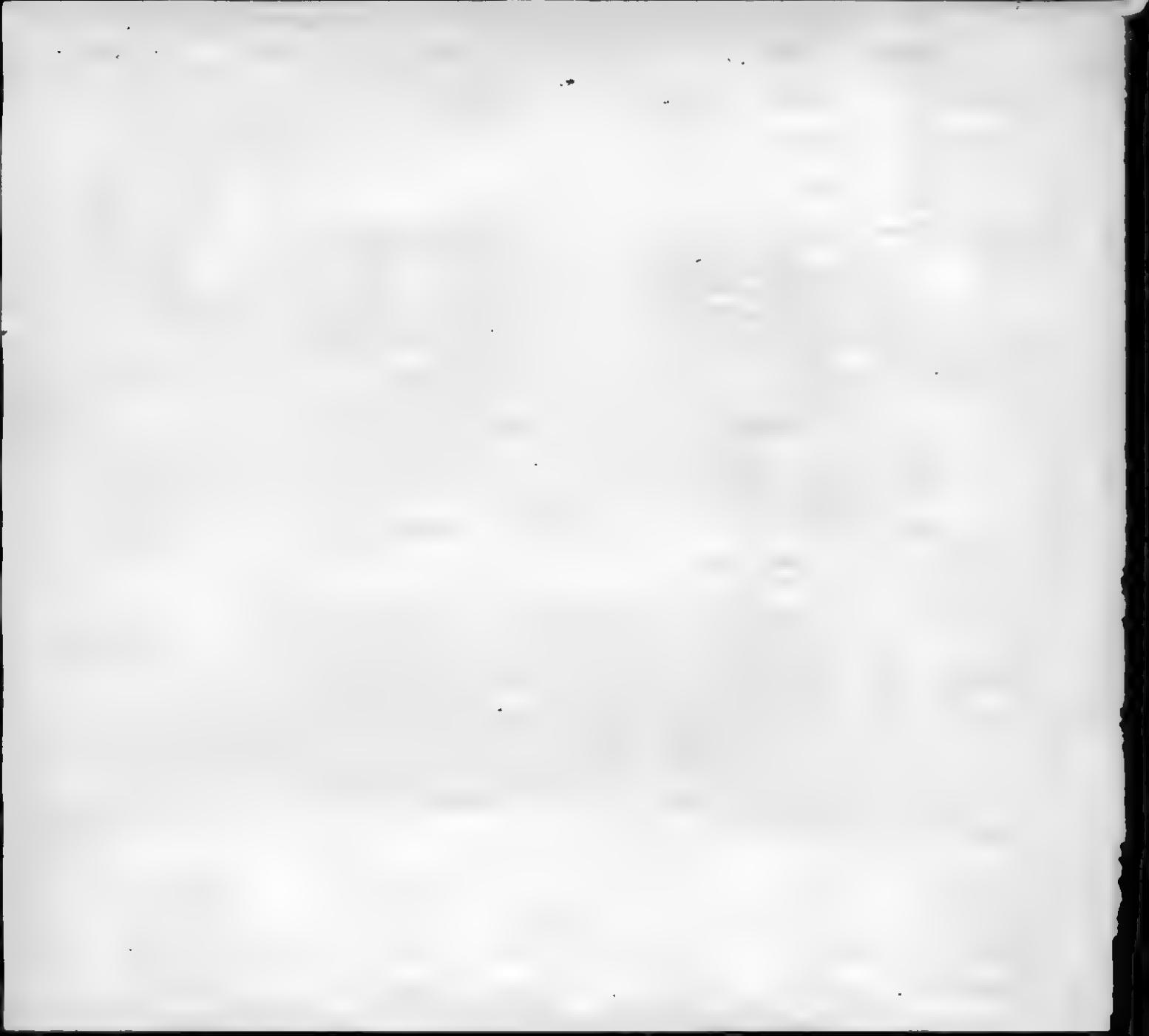
Robert A. Pumphrey Bethesda, Maryland

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE JUN 3 '59

Arthur S. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05802

5816

CERTIFICATE OF DEATH

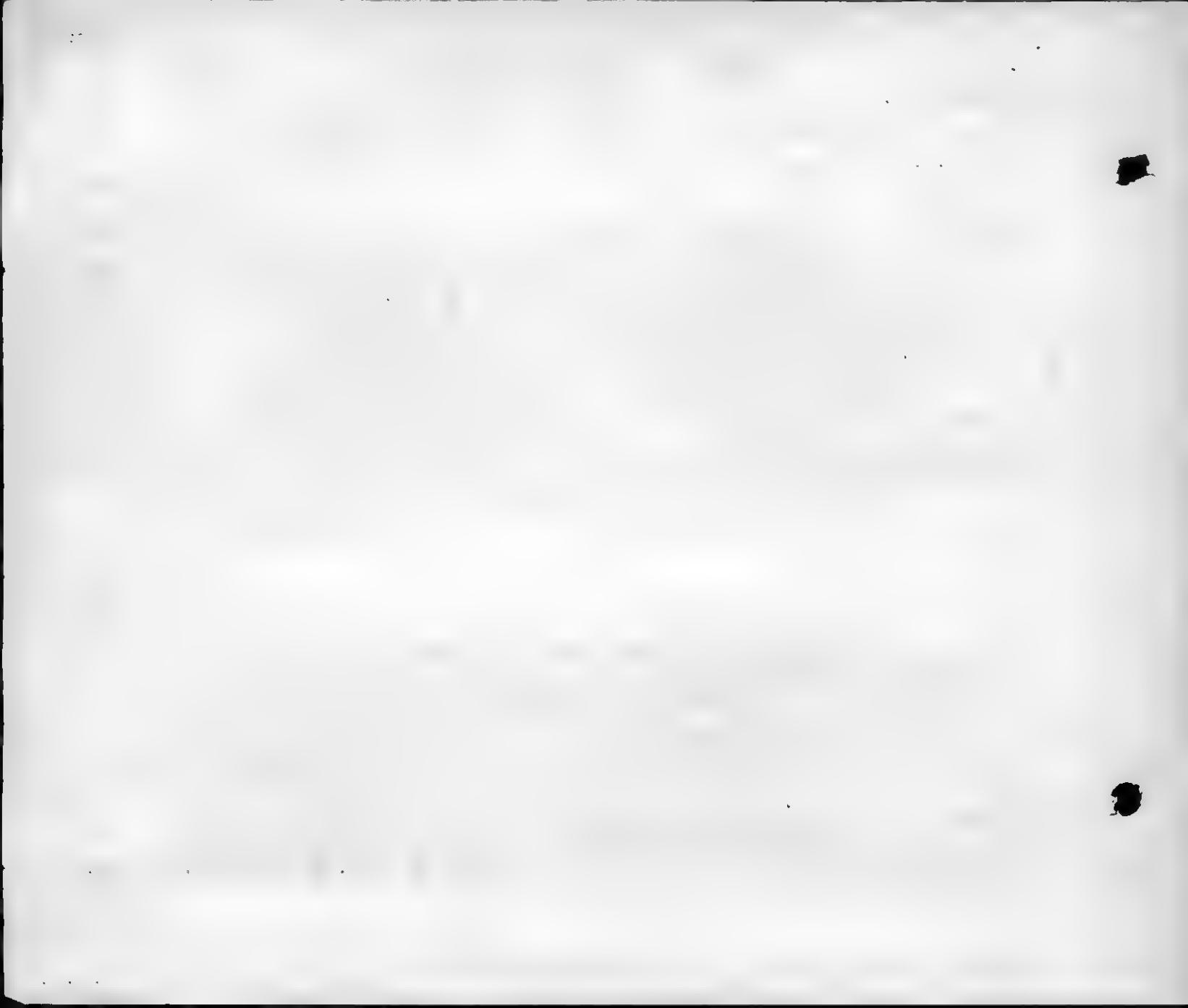
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived—If institution, Residence before admission) a. STATE		DC		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 15 1/2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Kensington Gardens Sanitarium		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First May	Middle T	Lost Miller	4. DATE OF DEATH	Month May	Day 29	Year 1959
5. SEX		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 16, 1879	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Jacob Ramminger		14. MOTHER'S MAIDEN NAME Mary Riordon						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Ruth Blackburn		Address 5028 Allan Rd.		
NO								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 1 year						
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carcinomatosis						
151X		DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Carcinoma of Stomach						
(b)								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from <u>June</u> , 1953, to <u>May</u> , 1959, that I last saw the deceased alive on <u>May 28</u> , 1959, and that death occurred at <u>6:15 pm</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 1801 Eye St. N.W. Wash. 6 DC						
ACTUAL SIGNATURE <i>M.H. Stolar M.D.</i>		DATE SIGNED						
PHYSICIAN'S NAME (Type) M.H. Stolar M.D.		1801 Eye St., N.W., Wash. 6, D.C.						
22a. BURIAL, CREMATION, REMOVAL (Specify) 5/30/59		22b. DATE THEREOF 5/30/59		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		22d. LOCATION (City, town, or county) Suitland, Md		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph A. Stolar Jr.</i>		ADDRESS 1756 Penn Ave. Wash. D.C.		24a. REC'D BY REGISTRAR DATE JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5817

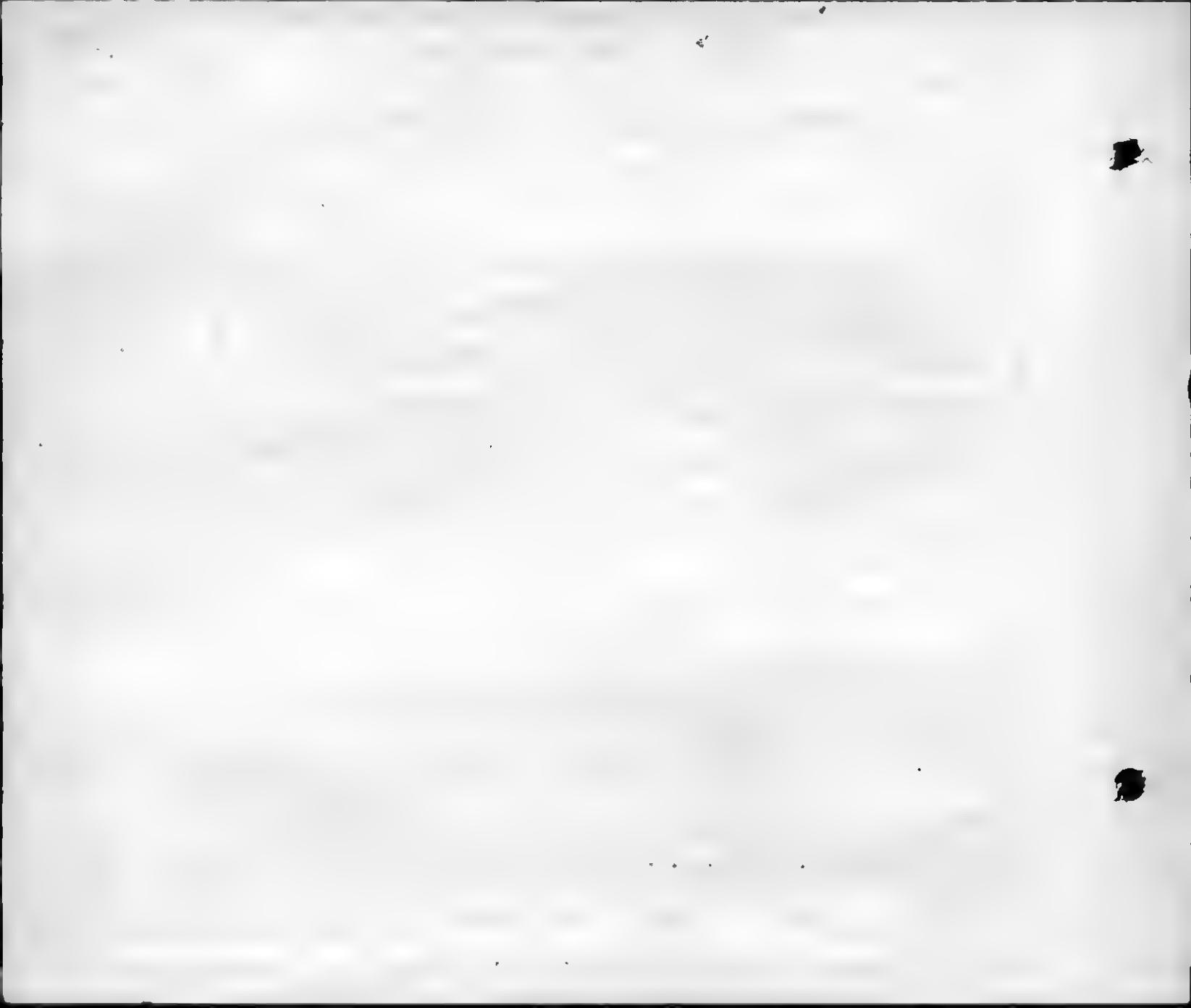
CERTIFICATE OF DEATH

05803

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
 Page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE MARYLAND	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Silver Spring		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Silver Spring	
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION 10104 Georgia Avenue		d. STREET ADDRESS 10104 Georgia Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VICTORIA		First MONCHICK	Middle Last 4. DATE OF DEATH May 14, 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1892
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Housewife		10b. KIND OF BUSINESS OR INDUSTRY Austria	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Waschler		14. MOTHER'S MAIDEN NAME Fanny Higger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Louis Monchick 10104 Georgia Avenue, S.S., Md.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH @ 6 HRS	
(b) ATHEROSCLEROTIC HEART DISEASE DUE TO (c)		18 MOS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CONGESTIVE HEART FAILURE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10620 GEORGIA AVE	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 23, 1959 , to MAY 14, 1959 , that I last saw the deceased alive on MAY 14, 1959 , and that death occurred at 1145 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 GEORGIA AVE DATE SIGNED Edward A. Beeman M.D. 10620 GEORGIA AVE			
ACTUAL SIGNATURE Edward A. Beeman		DATE SIGNED 10620 GEORGIA AVE	
PHYSICIAN'S NAME (Type) Edward A. Beeman, M.D.		SILVER SPRING, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-15-59	22c. NAME OF CEMETERY OR CINNATORY Baker Street Cemetery	22d. LOCATION (City, town, or county) (State) Boston, Massachusetts
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons—3501-14th St., N.W.		24a. REC'D BY REGISTRAR MAY 18 '59	24b. REGISTRAR'S SIGNATURE Orchard St. 16



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

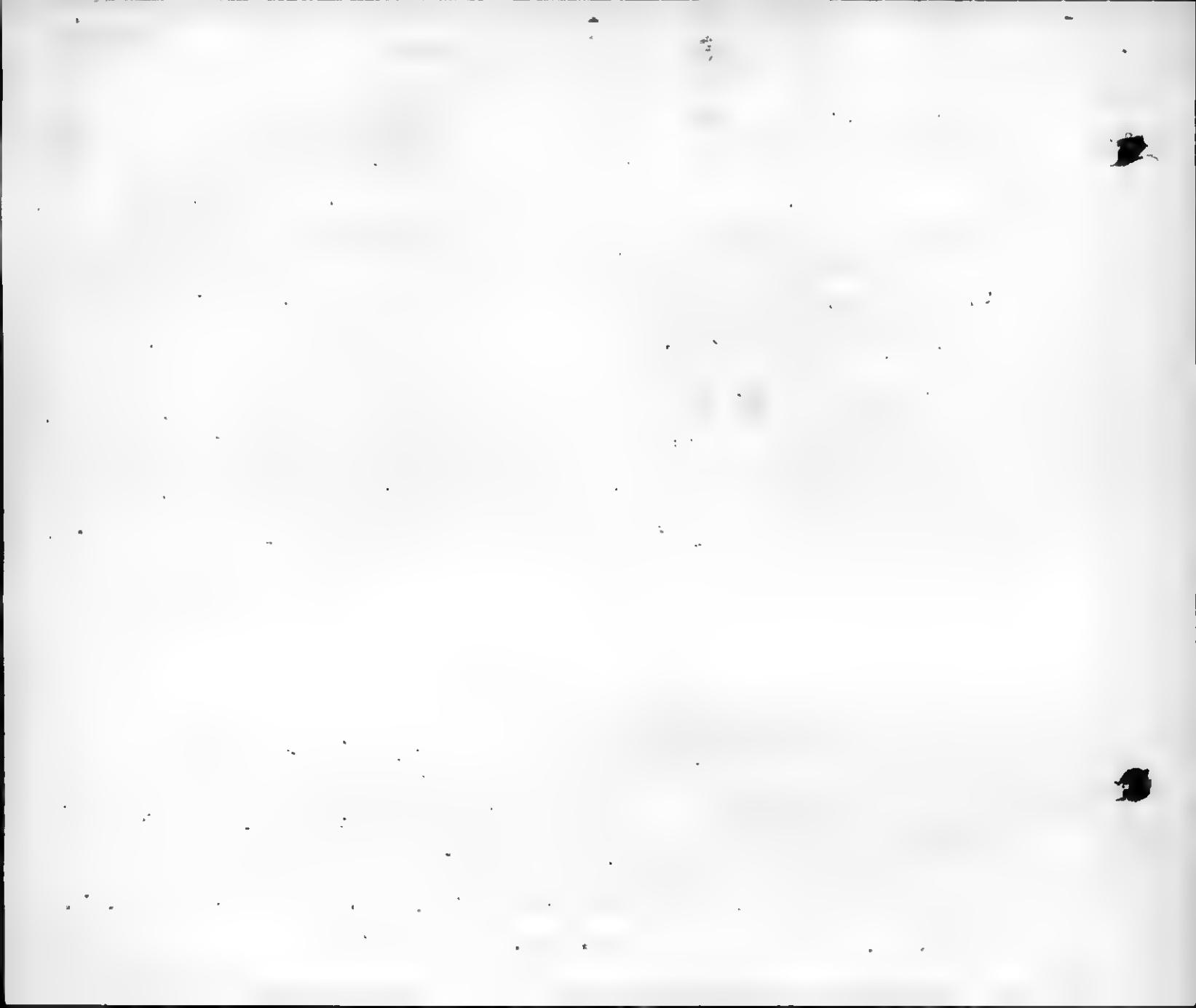
5818 CERTIFICATE OF DEATH

05804

Reg. Dist. No

○ FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 2517 PLYERS MILL ROAD		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				d. STREET ADDRESS SILVER SPRING		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOHN MOTT		First	Middle	Lost	4. DATE OF DEATH MORSE	Month 5	Day 1	Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-1885	9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS Days 24	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANUFACTURER		10b. KIND OF BUSINESS OR INDUSTRY MANUFACTURING		11. BIRTHPLACE (State or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME NATHANIAL MORSE		14. MOTHER'S MAIDEN NAME CYNTHIA SHARP						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT Mes. MARTHA ELLEN KODECKY		Address 10411 HUTTING PT S.S. MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 2 years		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic Heart Disease								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DUE TO 								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. 10511 SUMMIT AVE	(County)	(State) KENSINGTON, MD.		
21. I certify that I attended the deceased from Dec. 1958, to April 30, 1959 , that I last saw the deceased alive on May 1, 1959 , and that death occurred at 3:15 PM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 5-1-59		DATE SIGNED		
ACTUAL SIGNATURE George Sharpe								
PHYSICIAN'S NAME (Type) George Sharpe M.D.								
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-transit		22b. DATE THEREOF 5-3-59		22c. NAME OF CEMETERY OR CREMATORIAL Onondaga Valley Cem.		22d. LOCATION (City, town, or county) Onondaga County, N. Y.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

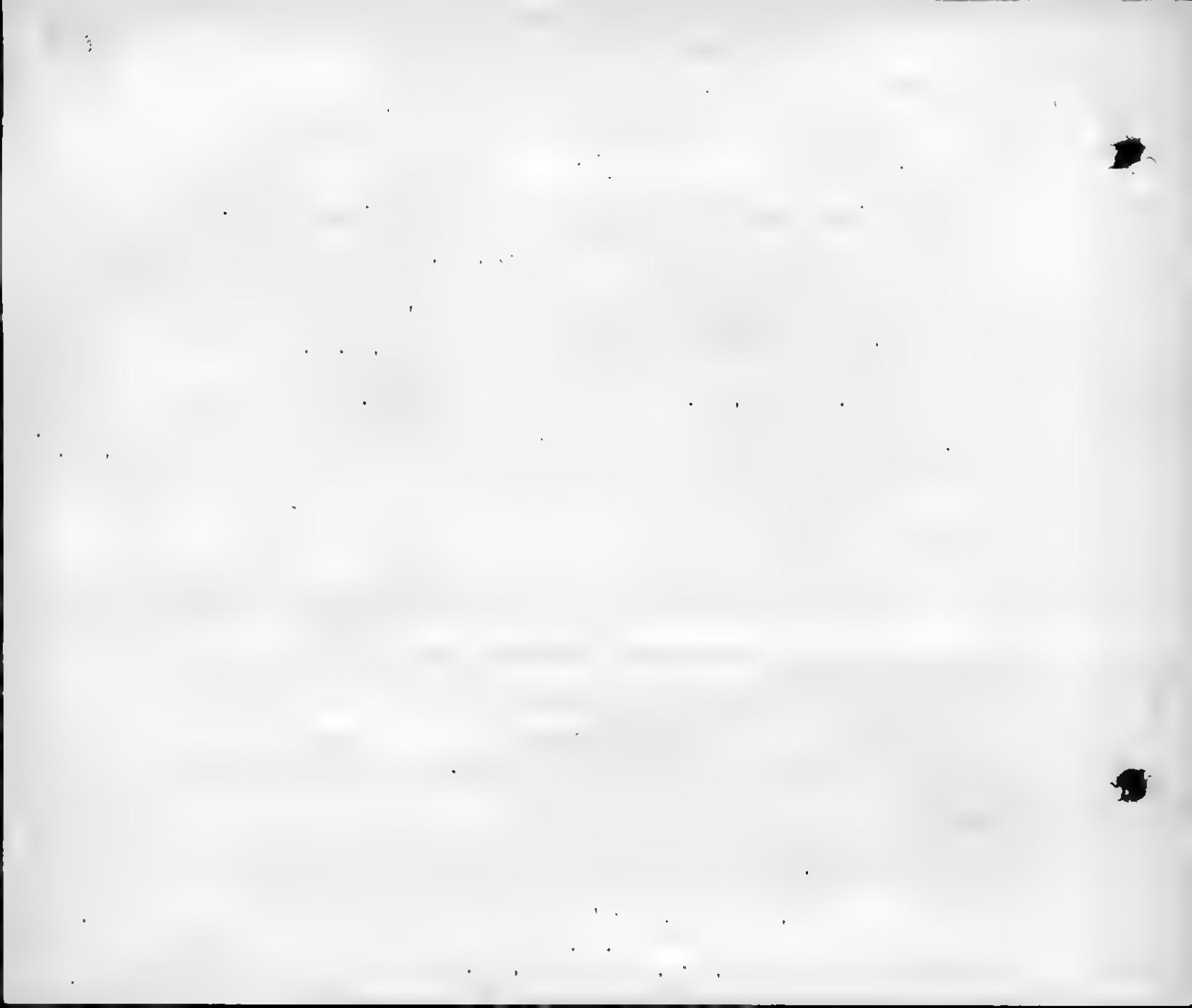
05805

5820 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Havarest Nursing Home 571 University Lane			d. STREET ADDRESS 103 Commonwealth Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First David	Middle Boyd	Last Murdock, Jr.	4. DATE OF DEATH May 17	Month Year Day 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 16, 1885	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman (R)		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME David B. Murdock, Sr.			14. MOTHER'S MAIDEN NAME Annie E. Williams		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No.		16. SOCIAL SECURITY NO. 577 07 6841A		17. INFORMANT Grace C Long	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs ?		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) April 17, 1959	
20f. (City or town) Silver Spring, Md.				(County) (State)	
21. I certify that I attended the deceased from April 17, 1959, to April 17, 1959, that I last saw the deceased alive on May 17, 1959, and that death occurred about 4 PM from the causes and on the date stated above.					
ACTUAL SIGNATURE William D. Aud		M.D.		ADDRESS (Street, city or town, state) 906 Collosville Rd 57157 Silver Spring, Md.	
DATE SIGNED					
PHYSICIAN'S NAME (Type) William D. Aud					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF May 20, 1959		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Catholic	
22d. LOCATION (City, town, or county) Alexandria		(State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE W. Beverly Mountcastle Cunningham Funeral Home, Inc.		ADDRESS P. O. Box 65 Alexandria, Va.		24a. REC'D BY REGISTRAR DAMAY 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

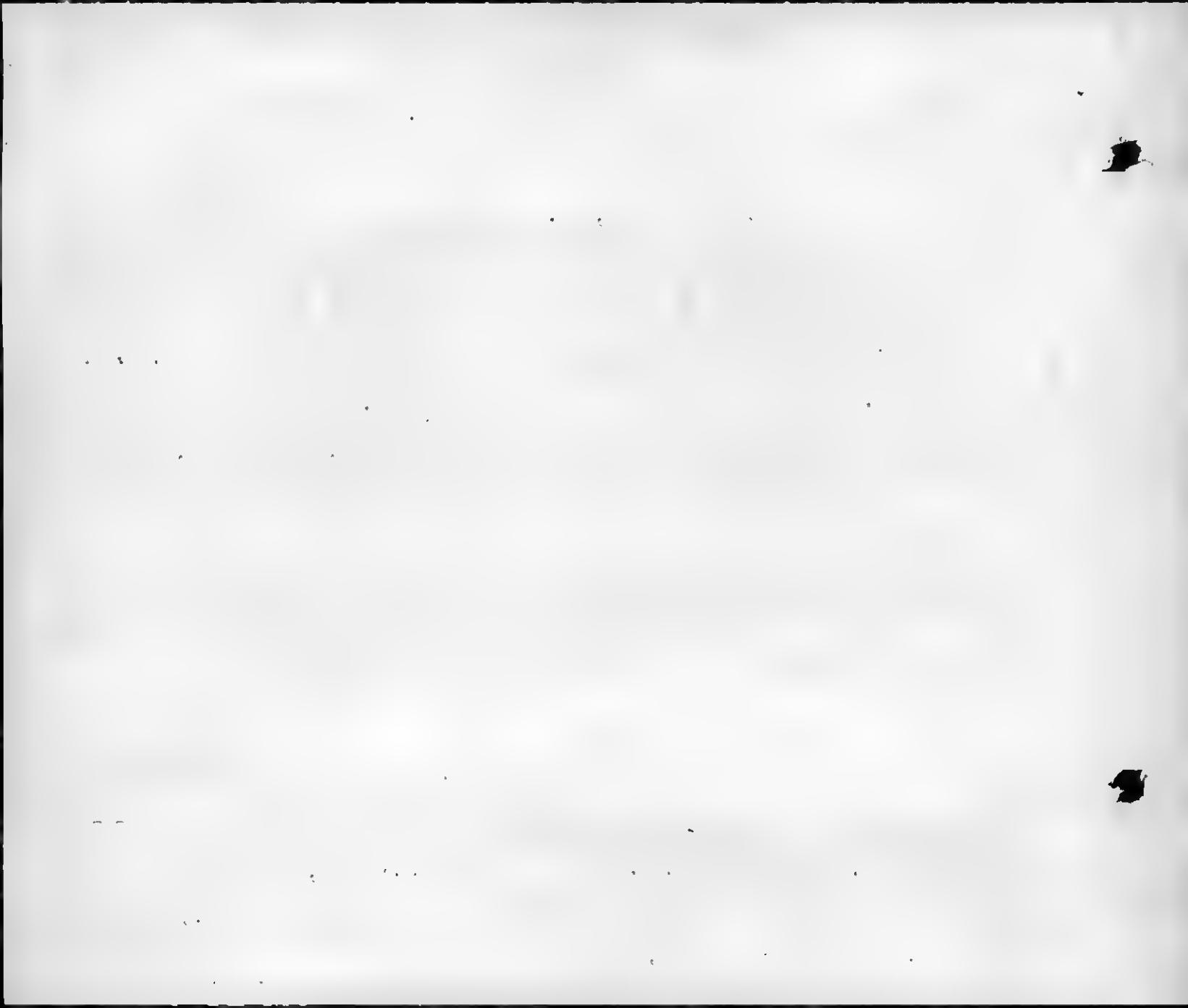
5821

CERTIFICATE OF DEATH

05806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Virginia		b. COUNTY Norfolk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 505 Lamar Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lamar	Middle Law	Last Murphy	4. DATE OF DEATH	Month May	Day 4	Year 1959
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 20, 1901	9. AGE (In years last birthday) 57 yr	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical Work		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME William J. Murphy				14. MOTHER'S MAIDEN NAME Mary E. Bohle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO WW II		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 24, 1959, to May 4, 1959, that I last saw the deceased alive on May 4, 1959, and that death occurred at 8:35 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE <i>G. Richard Lee</i>		M.D.		DATE SIGNED 5-5-59			
PHYSICIAN'S NAME (Type) G. Richard Lee, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 5/9/59		22c. NAME OF CEMETERY OR CREMATORIAL Rosewood Memorial		22d. LOCATION (City, town, or county) (State) Princess Ann Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR MAY 8 59 DATE		24b. REGISTRAR'S SIGNATURE <i>Conrad J. Mann</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

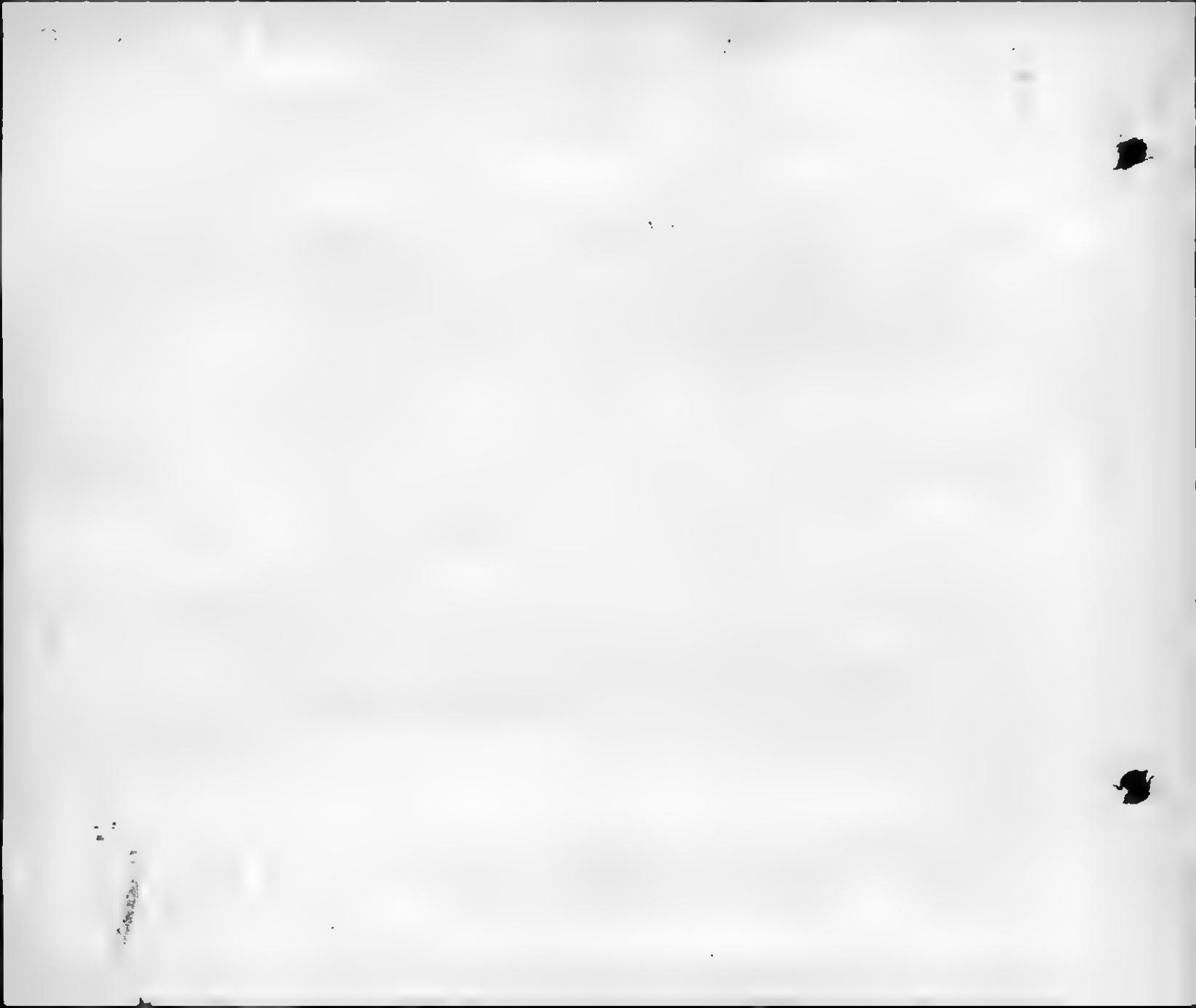
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5822 06979

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brookland</i>		c. LENGTH OF STAY IN 1b <i>60 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bethesda Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>James E. Neacy</i>		First <i>J</i>	Middle <i>E</i>
4. DATE OF DEATH Month <i>5</i> Day <i>29</i> Year <i>1959</i>		5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Unknown</i>	
9. AGE (In years lost birthday) <i>89 yrs</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Armstrong</i>	11. KIND OF BUSINESS OR INDUSTRY <i>—</i>
12. CITIZEN OF WHAT COUNTRY <i>US</i>		13. FATHER'S NAME <i>James Neacy</i>	
14. MOTHER'S MAIDEN NAME <i>McNally</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> [Yes, no, or unknown] <i>No</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>William Neacy</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ischemia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bilateral Pyleitis</i> DUE TO (c)		Address <i>206 Pumford St., Chevy Chase, Md.</i>	
19. INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18] —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>May 29 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Wash DC</i>	
21. I certify that I attended the deceased from <i>5/28/59</i> to <i>5/29/59</i> , that I last saw the deceased alive on <i>5/27/59</i> , and that death occurred at <i>11 a.m.</i> from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>County of Md.</i> DATE SIGNED <i>5/29/59</i>			
ACTUAL SIGNATURE <i>JM Neacy</i>		PHYSICIAN'S NAME (Type) <i>Arthur S. Kline</i>	
22a. BURIAL/CREMATION REMOVAL (Specify) <i>—</i>		22b. DATE THEREOF <i>5-2-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) <i>Wash DC</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kline</i>		ADDRESS <i>3831 39th Ave NW</i>	
24a. REC'D BY REGISTRAR <i>Arthur S. Kline</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5823

CERTIFICATE OF DEATH

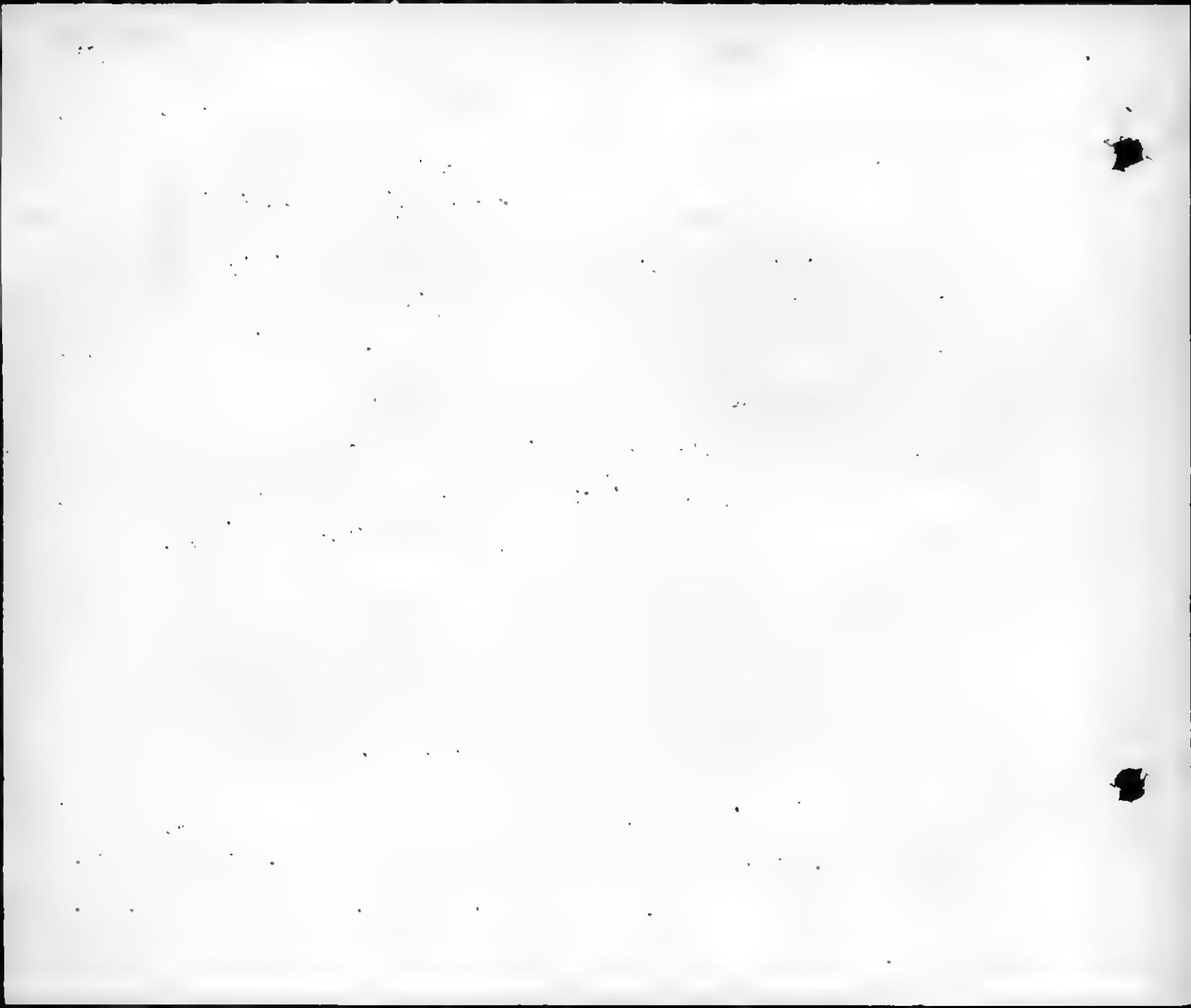
05807

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if instit. or residence before admission) a. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i></i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			
3. NAME OF DECEASED (Type or print) <i>William Charles Nicholson</i>		4. DATE OF DEATH Month <i>May</i>	Day Year <i>3 1959</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/29/96</i>		
9. AGE (In years, last birthday) <i>62 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate Broker</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Broker</i>	12. BIRTHPLACE (State or foreign country) <i>DICKERSON Md</i>		
13. FATHER'S NAME <i>Claude Nicholson</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>579-03-2769</i>	17. INFORMANT <i>Wife - Same as above</i>	18. ADDRESS		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CANCER (SMALL-CELL) OF LEFT LUNG</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>10 mo.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		20. DUE TO (b) DUE TO (c) <i>METASTATIC CANCER TO CERVICAL VERTEBRA</i>		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i></i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Bethesda</i>	(County) <i>Montgomery</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>1956</i> to <i>1959</i> , that I last saw the deceased alive on <i>MAY 2, 1959</i> , and that death occurred at <i>1:20 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>8218 Wisconsin Ave., Bethesda</i>					
ACTUAL SIGNATURE <i>Leo M. Curtis</i>	DATE SIGNED <i>5/5/59</i>				
PHYSICIAN'S NAME (Type) <i>Leo M. Curtis</i>	8218 Wisconsin Ave. Bethesda, Md.				
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/5/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cemetery</i>	22d. LOCATION (City, town, or county) <i>Prince George Co. Md.</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>	ADDRESS <i>Bethesda, Maryland</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 5 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur & Krause</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

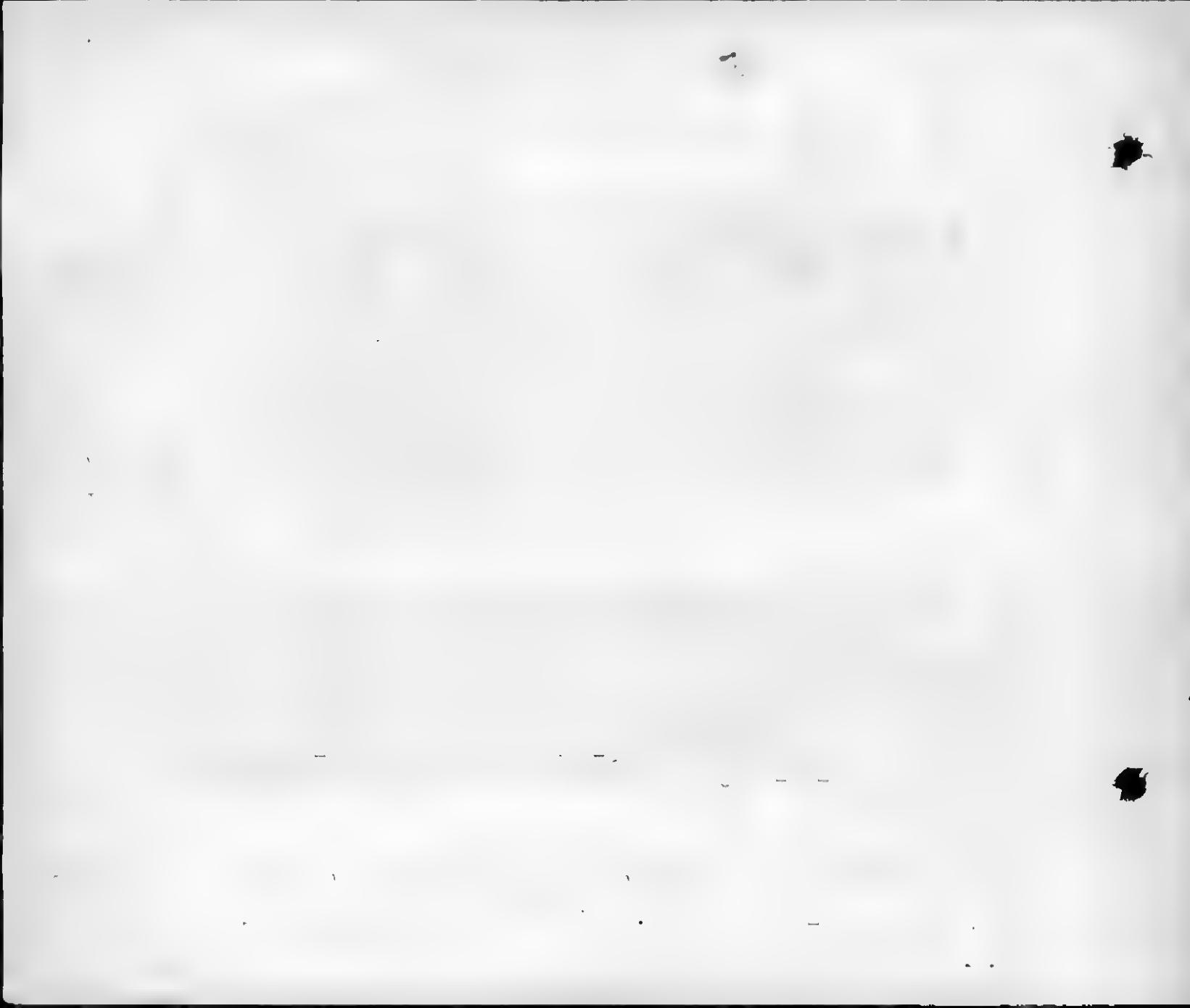
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5824 CERTIFICATE OF DEATH

Reg. Dist. No. 05808

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Montgomery		b. COUNTY Howard					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Maryland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville		d. STREET ADDRESS Trotter Road					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Janet Eileen Niemann		First	Middle	Last	4. DATE OF DEATH May 30 1959	Month	Day	Year			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 28, 1959	9. AGE (In years lost birthday) yrs 2	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born			11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME William Robert Niemann		14. MOTHER'S MAIDEN NAME Mary Margaret Dorothy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, no, or unknown] (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atelectasis, bilateral			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 5-28- 1959 to 5-30- 1959 , that I last saw the deceased alive on 5-30- 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE <i>Charles S. Whitaker</i>		PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		ADDRESS (Street, city or town, state) Clarksville, Maryland		DATE SIGNED 5-31-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-2-1959		22c. NAME OF CEMETERY OR CREMATORIAL St. Louis		22d. LOCATION (City, town, or county) Clarksville, Md		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 2 '59		24b. REGISTRAR'S SIGNATURE Charles S. Whitaker					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05809

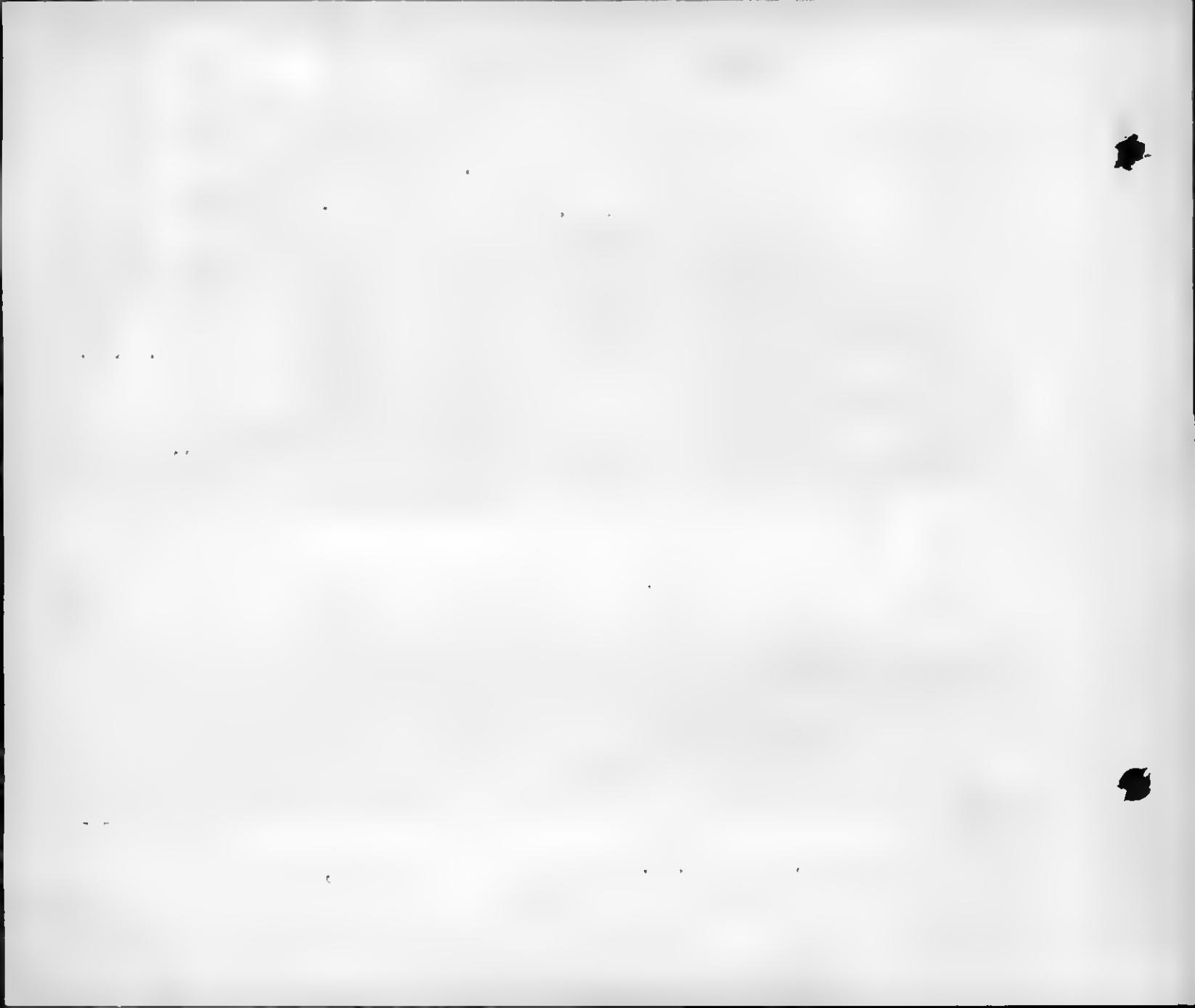
5825

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 86 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		16 1/2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3711 Eastern Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Evelyn	Middle Minnie	Last Noblette	4. DATE OF DEATH May 6, 1959	Month May	Day 6	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 3, 1903	9. AGE (In years last birthday) 55 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward McAbee				14. MOTHER'S MAIDEN NAME Minnie Morgan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 248-09-4926		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vascular Collapse				INTERVAL BETWEEN ONSET AND DEATH 4 days			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) Lymphosarcoma				6 years			
DUE TO (c) ? Pseudomonas Septicemia				4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from February 9, 1959, to May 6, 1959, that I last saw the deceased alive on May 6, 1959, and that death occurred at 7:55 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Edgar H. Levin, M. D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-9-1959	22c. NAME OF CEMETERY OR CREMATORIAL FORT LINCOLN CEMETERY	22d. LOCATION (City, town, or county) COLMAR MANOR, MD.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland	24a. REC'D BY REGISTRAR DATE MAY 11 '59	24b. REGISTRAR'S SIGNATURE C. L. S. & T. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director,
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

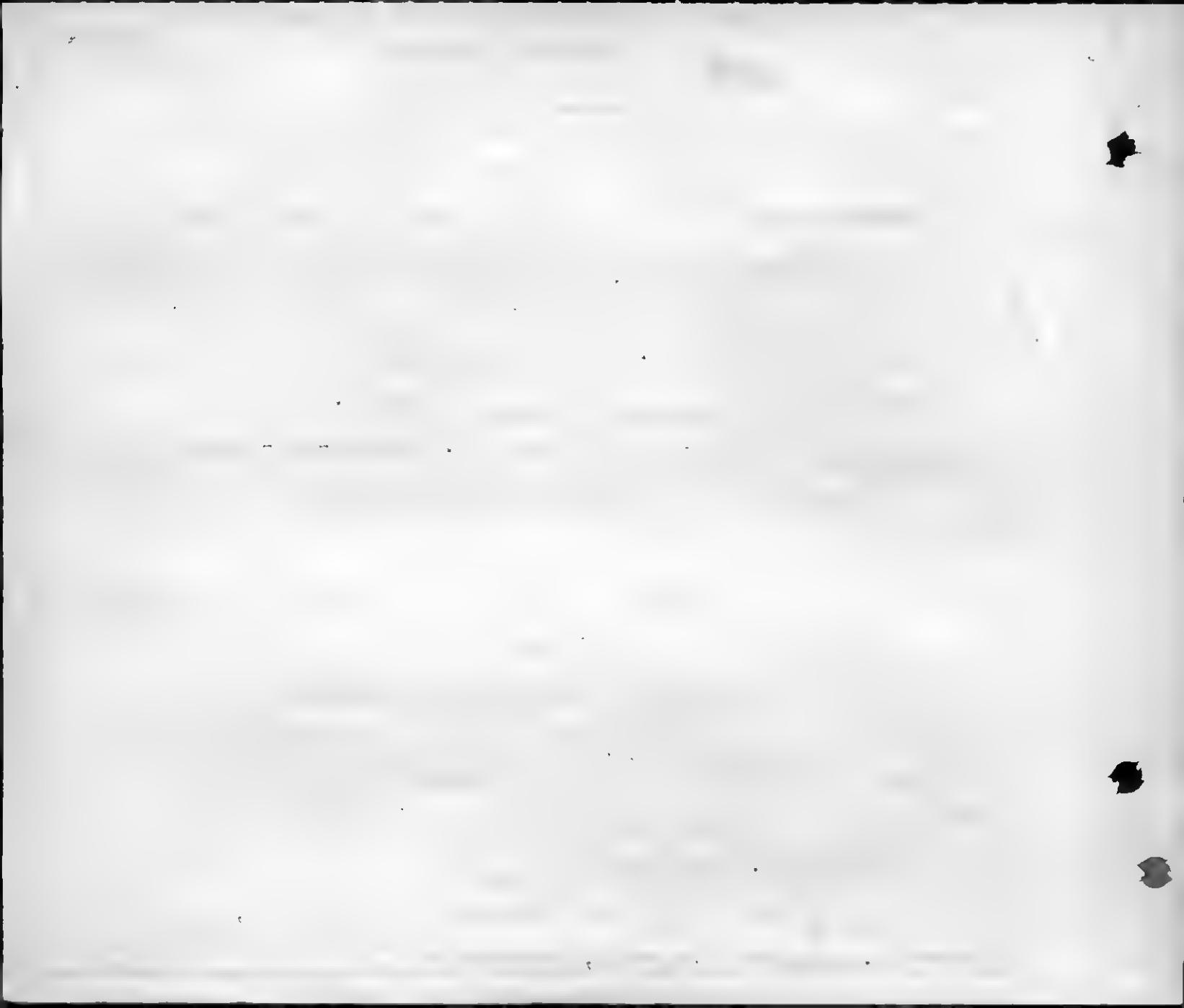
05810

Reg. Dist. No.

5728

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 106 Charles Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 106 Charlest Street				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THOMAS LENOX ORRISON				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) THOMAS LENOX ORRISON		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/79	9. AGE (In years lost birthday) 79 yn.	10. IF UNDER 1 YEAR Months 6 Days 2	11. IF UNDER 24 HRS Hours 2 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Montg. County		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Kate B. Wren						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-18-1837		17. INFORMANT George L. Orrison-son-same as 2d		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLIZATION						INTERVAL BETWEEN ONSET AND DEATH 72 HOURS				
162.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO HEPATIC COMA						TWO DAYS				
(c) DUE TO BRONCHIOGENIC CARCINOMA						8 MONTHS				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO-OCCLUSIVE HEART DISEASE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 26 N. SUMMIT AVE. GAITHERSBURG, MARYLAND		20f. (City or town) GAITHERSBURG, MARYLAND		(County) MONTGOMERY	(State) MARYLAND	
21. I certify that I attended the deceased from FEB. 12 , 1959, to MAY 6 , 1959, that I last saw the deceased alive on MAY 5 , 1959, and that death occurred at 4 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 26 N. SUMMIT AVE. GAITHERSBURG, MARYLAND			DATE SIGNED MAY 8 1959	
ACTUAL SIGNATURE <i>Gordon S. Rosenberger</i>										
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/8/59		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) Rockville, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D. BY REGISTRAR DATE MAY 8 1959		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thrall</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.

NO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15MS
SM 2/57

6 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5826

05811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville		c. LENGTH OF STAY IN TB 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Barnesville		d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)									
e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
3. NAME OF DECEASED (Type or print)		First Bertha	Middle Helen	Last Painter	4. DATE OF DEATH May 29 1957	Month May	Day 29	Year 1957	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-1892	9. AGE (in years, months and birthday) 66 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George H. Hildebrand		14. MOTHER'S MARRIED NAME Ruth Davis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE 17. INFORMANT Elmer Painter (husband) Item 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary occlusion IMMEDIATE CAUSE (a), stating the underlying cause last. Due to (c) sudden								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. 19 p. m.		Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bearsville	(County) Montgomery	(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Borschert	M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-29-57		
EXAMINER'S NAME (Type) Frank J. Borschert					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 6/1/59		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Monocacy		22d. LOCATION (City, town, or county) Bearsville		(State) Md		
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hellen, Barnesville, Md		24a. REC'D BY REGISTRAR JUN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5827

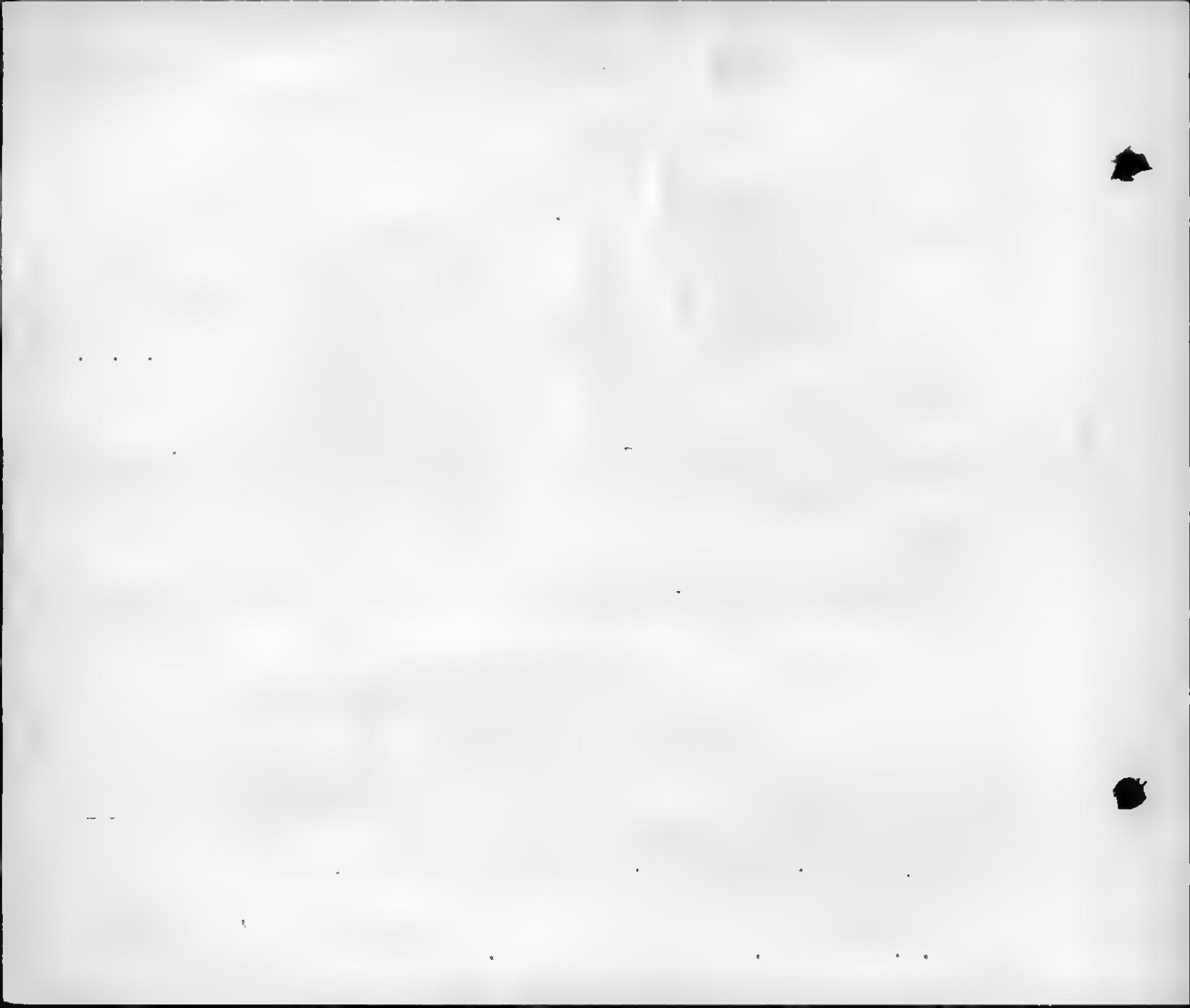
CERTIFICATE OF DEATH

Reg. Dist. No.

05812

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Pennsylvania		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Saint Benedict		d. STREET ADDRESS Box 186	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Helen	Middle (none)	Last Pawliske	4. DATE OF DEATH	Month May	Day 6	Year 1959
5. SEX	6. COLOR OR RACE Female	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH September 29, 1916	9. AGE (in years last birthday) 42 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME George Mandrick				14. MOTHER'S MAIDEN NAME Anna Kutsick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO No		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 171X DUE TO Metastatic Carcinoma, Advanced INTERVAL BETWEEN ONSET AND DEATH 6 Months							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b) DUE TO Pyelonephritis, Chronic 8 Months					
(c) DUE TO Carcinoma of Cervix 11 Months							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 4, 1959, to May 6, 1959, that I last saw the deceased alive on May 6, 1959, and that death occurred at 2:40 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Dillon</i>		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5/8/1959		22c. NAME OF CEMETERY OR CREMATORIAL --		22d. LOCATION (City, town, or county) Carrolltown, Pennsylvania (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.		ADDRESS Washington 9, D.C.		24a. REC'D BY REGISTRAR MAY 8 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

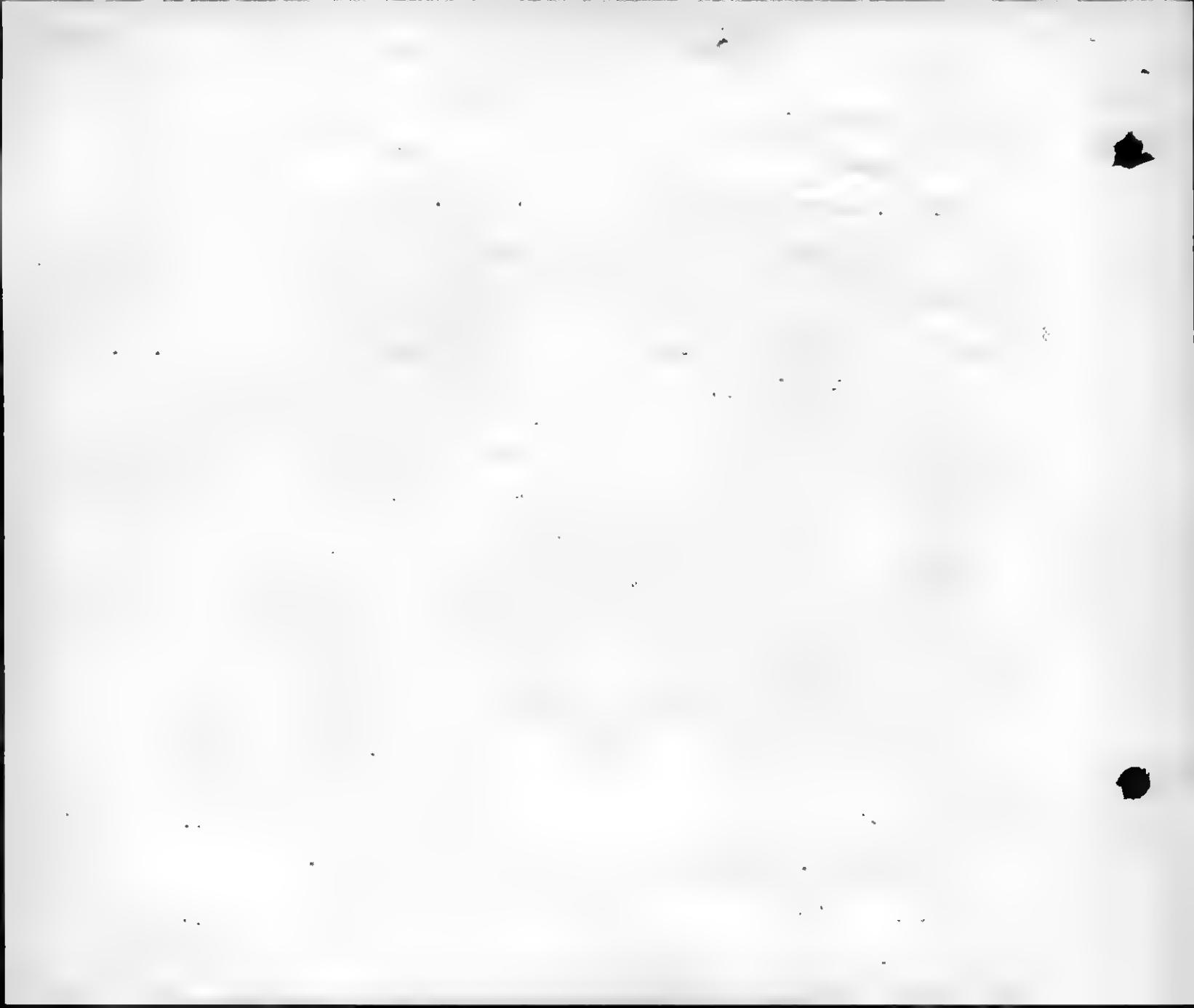
5828 CERTIFICATE OF DEATH

Reg. Dist. No.

05813

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 4612 N. Chelsea Lane				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4612 N. Chelsea Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) JUDITH		First MARY	Middle 	Last PERRELL	4. DATE OF DEATH 3 22 1959	Month 3	Day 22	Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/18/57	9. AGE (In years lost birthday) 2 yrs.	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 4	12. Hours 	13. IF HOURS Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.				
13. FATHER'S NAME Upton J. Jack Perrell, Jr		14. MOTHER'S MAIDEN NAME Margaret J Sartwell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		INFORMANT Jack Perrell (father)	Address Same as Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH 20 min								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7545		DUE TO <i>Acute congestive heart failure</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. -----		DUE TO <i>Congestive heart failure - some</i>								
DUE TO -----		DUE TO <i>hypertension</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) -----		(County) -----	(State) -----	
21. I certify that I attended the deceased from Dec 27, 1958 to Mar 2, 1959 , that I last saw the deceased alive on Mar 20, 1959 , and that death occurred at 8:30 M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Leo I. Donovan</i>		ADDRESS (Street, city or town, state) -----								DATE SIGNED 5/23/59
PHYSICIAN'S NAME (Type) LEO I. DONOVAN		M.D. 8016 Old Georgetown Rd.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) Rockville, Maryland		(State) -----		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR Arthur L. Krause		24b. REGISTRAR'S SIGNATURE -----				
VS A15 (4) 15M 9/58		DATE MAY 27 '59								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

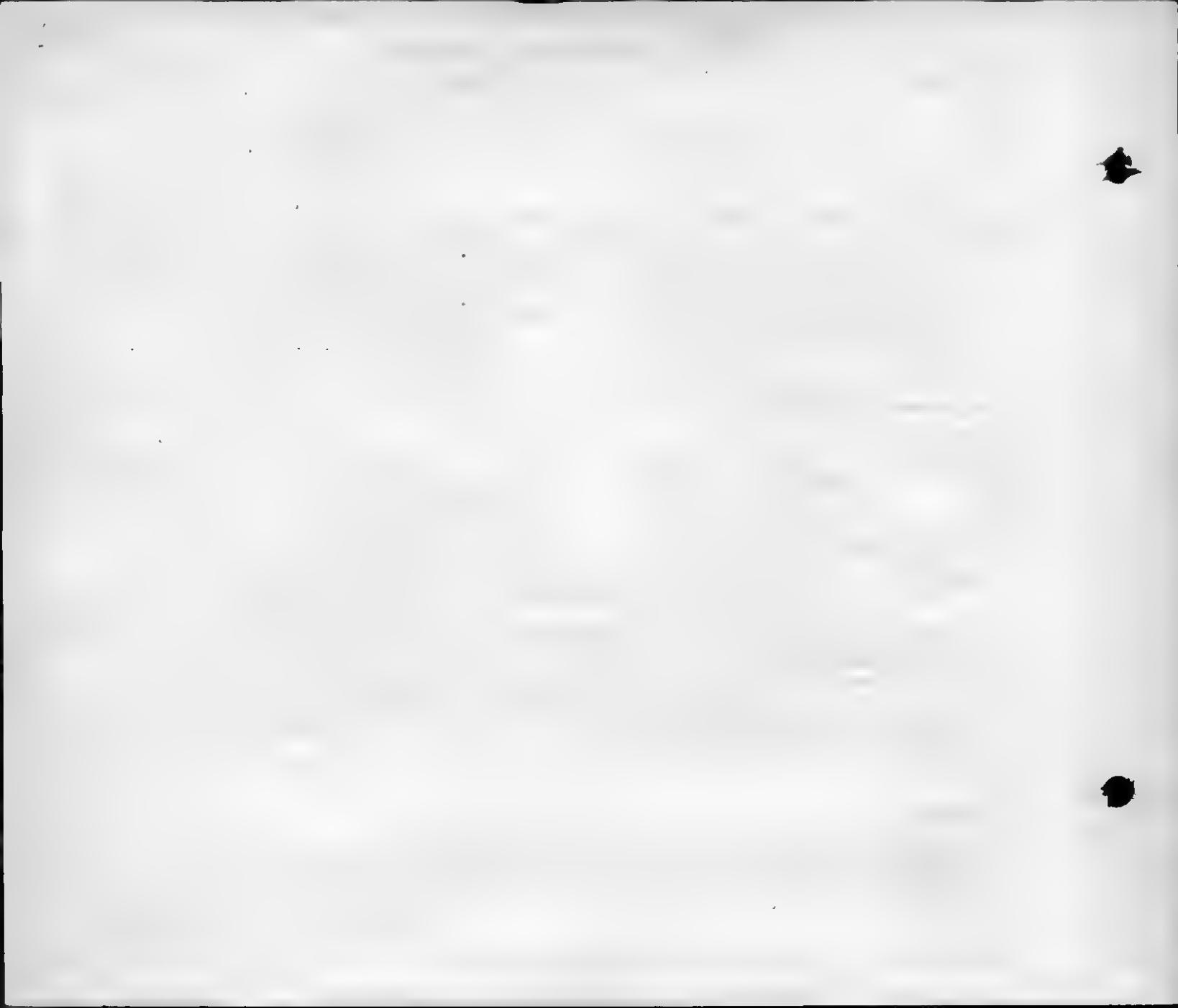
5829

CERTIFICATE OF DEATH

Reg. Dist. No.

05814

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 5006 - Dalton Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Residence				d. STREET ADDRESS 5006 - Dalton Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LOTTIE	Middle LOUISE	Last PERRY.	4. DATE OF DEATH	Month May	Day 16	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1892		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James S Perry		14. MOTHER'S M AIDEN NAME Ada E Ward					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Ralph Perry - same as above.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331 X</u> DUE TO <u>Cerebral hemorrhage</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last. (b) <u>Generalized arteriosclerosis</u> 1.5 months (c) <u>with hypertension</u> 2 years. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 17</u> , 1959, to <u>5-15-1959</u> , that I last saw the deceased alive on <u>5-15-1959</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>C P Ryland</u> ADDRESS (Street, city or town, state) <u>4400-49 81 NW</u> DATE SIGNED <u>5-16-59</u> PHYSICIAN'S NAME (Type) <u>C P RYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF May 17, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Lees Crematorium		22d. LOCATION (City, town, or county) Washington D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		ADDRESS		24a. REC'D BY REGISTRAR MAY 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5830 CERTIFICATE OF DEATH

Reg. Dist. No. 05815

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Holabird St. Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>8 mos</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Belmont Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Holabird St. Md.</i>	
3. NAME OF DECEASED (Type or print) <i>Robert F. Perry</i>		d. STREET ADDRESS <i>5203 60st Holabird</i>	
4. DATE OF DEATH <i>3 Month 2 Day 1959</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M.</i>		6. COLOR OR RACE <i>W.</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Unknown about 54 yrs.</i>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) <i>54 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	
11. BIRTHPLACE (State or foreign country) <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>Unknown</i>	
17. INFORMANT <i>Sawh Williams, P. J. Hoop, P. J. M.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterial Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arterio Sclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/13/59</i> to <i>5/2/59</i> , that I last saw the deceased alive on <i>4/3/59</i> , and that death occurred at <i>4A M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Sandy Hill Md.</i> DATE SIGNED <i>5/2/59</i>	
ACTUAL SIGNATURE <i>J. M. BIRD</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>J. M. BIRD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 5 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Boyz Barber</i>		ADDRESS <i>Laytonsville, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5718 CERTIFICATE OF DEATH

Reg. Dist. No. 05816

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>		c. LENGTH OF STAY IN 1b <i>7 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>21 Columbia Ave.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>	
3. NAME OF DECEASED (Type or print) <i>EMIL</i>		First <i>E</i>	Middle <i>M</i>
4. DATE OF DEATH <i>MAY 25 1954</i>		Month <i>MAY</i>	Day <i>25</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Never married</i>
8. DATE OF BIRTH <i>July 4 1886</i>		9. AGE (in years from last birthday) <i>72</i>	10. IF UNDER 1 YEAR Months <i>0</i>
11. BIRTHPLACE (State or foreign country) <i>DENMARK</i>		12. IF UNDER 24 HRS. Days <i>0</i>	13. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TRUCKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DRIVER</i>	
11. CITIZEN OF WHAT COUNTRY? <i>DENMARK</i>		12. CITIZEN OF WHAT COUNTRY? <i>DENMARK</i>	
13. FATHER'S NAME <i>CHRIS PETERSEN</i>		14. MOTHER'S MAIDEN NAME <i>ANKINSEN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO <i>123-45-6789</i>	
17. INFORMANT <i>MRS. E. PETERSEN (Same)</i>		Address <i>800 Pershing Avenue, 88 Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>INANITION</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 mos</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>INANITION, CIRCUMSTANCES</i>			
DUE TO <i>INANITION, CIRCUMSTANCES</i>			
DUE TO <i>INANITION, CIRCUMSTANCES</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 20 1954</i> to <i>May 25 1954</i> , that I last saw the deceased alive on <i>May 20 1954</i> , and that death occurred at <i>4 AM</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Franklin L. DeLong</i>		ADDRESS (Street, city or town, state) <i>800 Pershing Avenue, 88 Md</i> DATE SIGNED <i>3/28/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 29 1954</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Stephens Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George County, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Miller, 254 Carroll St NW DC</i>		24a. REC'D BY REGISTRAR DATE <i>SUN 1 '59</i>	
ADDRESS <i>254 Carroll St NW DC</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Evans</i>	



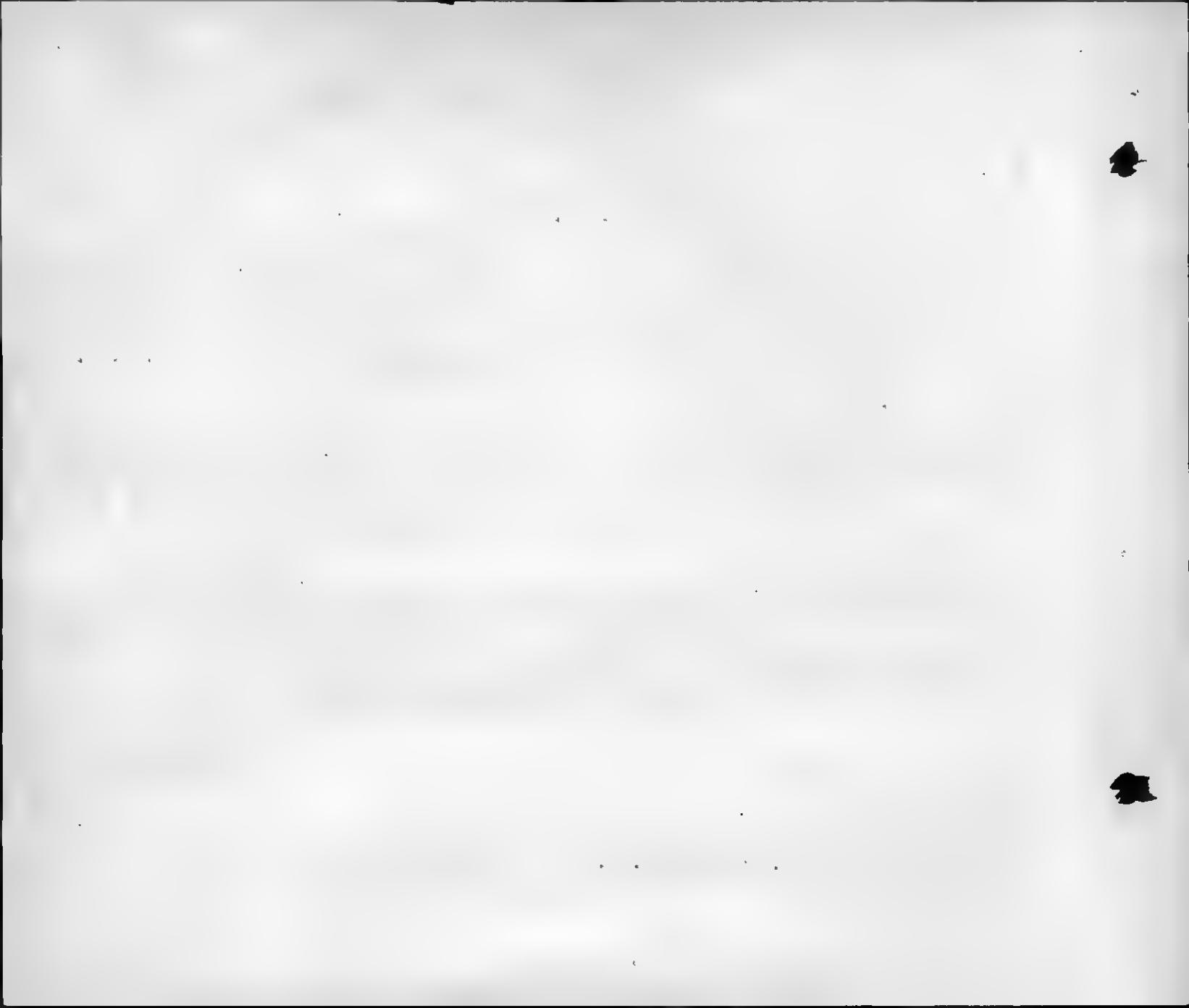
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5831 CERTIFICATE OF DEATH

Reg. Dist. No.

05817

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 120 Center Drive		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Janice		First	Middle	last	4. DATE OF DEATH May	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 27, 1927		9. AGE (In years last birthday) 31	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Robert L. Strickland				14. MOTHER'S MAIDEN NAME Ellen Carlson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of Breast to lymphatic, hepatic, lung systems. DUE TO (c) 5 mos.								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rochester	(County)	(State)
21. I certify that I attended the deceased from May 9, 1959, to May 16, 1959, that I last saw the deceased alive on May 16, 1959, and that death occurred at 10:27 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland								
ACTUAL SIGNATURE Donald A. Kellogg		M.D.		DATE SIGNED 5-17-59				
PHYSICIAN'S NAME (Type) Donald A. Kellogg, M. D.								
22a. BURIAL, CREMATION REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 5/17/59		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) Rochester, New York		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAY 19 '59						
		24b. REGISTRAR'S SIGNATURE Orville S. Kraus						



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File copies 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DERT.
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VS. A15ME
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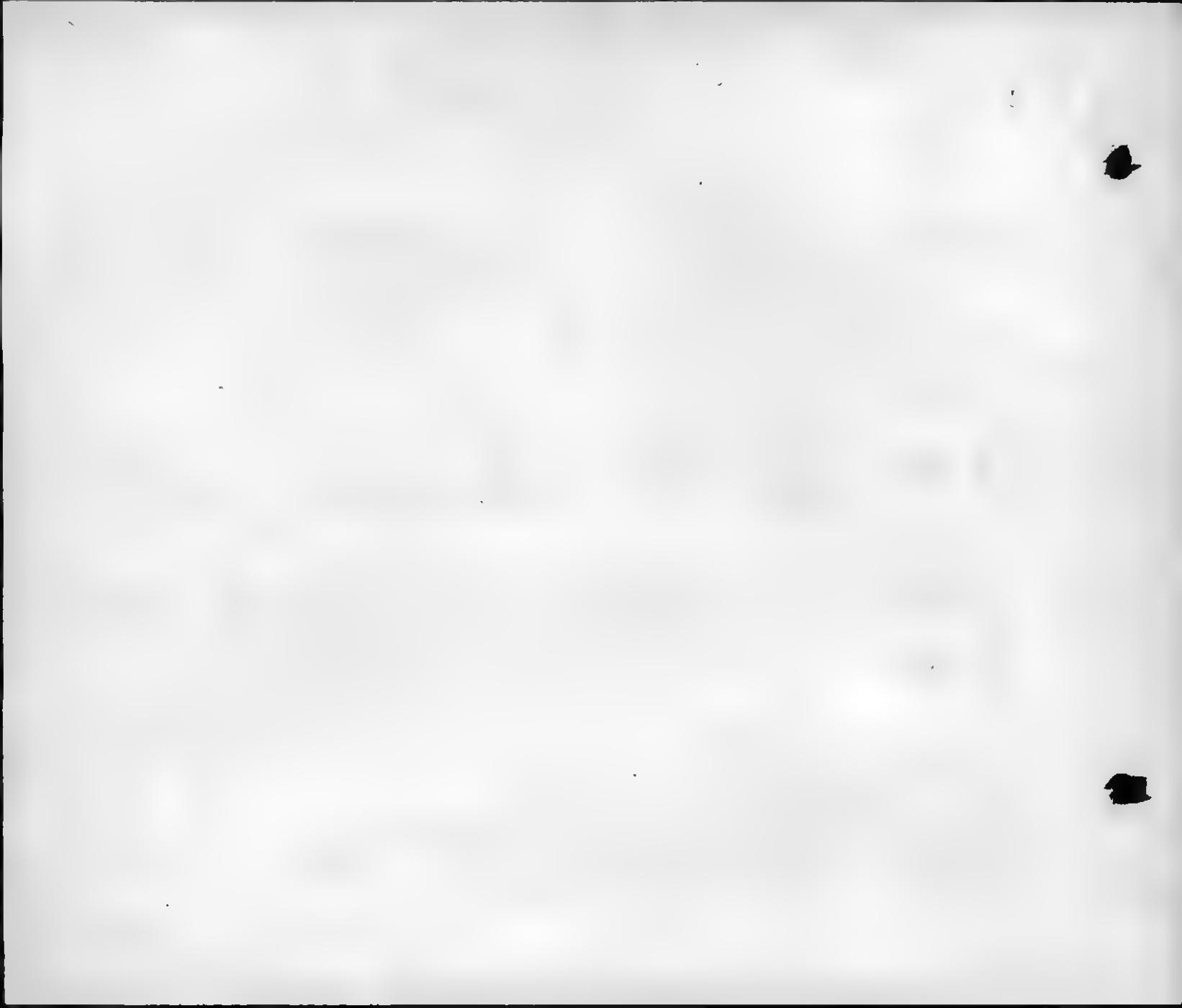
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5719 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05818

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	c. LENGTH OF STAY (In lbs) 35 min.							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring							
3. NAME OF DECEASED (Type or print) Phillip	f. STREET ADDRESS 8202 New Hampshire Ave.							
4. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	First Middle Phillip (N.M.N.)	5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-14	9. AGE (In years last birthday) 44 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Govt.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Turkey	12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Anthony Phillips	14. MOTHER'S MAIDEN NAME Frances Vitali							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Record						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
- coronary occlusion c myocardial infarction 1 hr. INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John G. Ball	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 8 May 1959			
EXAMINER'S NAME (Type) John G. Ball								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 12, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery	22d. LOCATION (City, town, or county) Arlington	(State) Virginia				
22e. FUNERAL DIRECTOR'S SIGNATURE Arthur Winters	22f. ADDRESS 254 Carroll St. N.E. A.C.	24a. REC'D BY REGISTRAR DATE MAY 11 '59	24b. REGISTRAR'S SIGNATURE Arthur & Anna					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

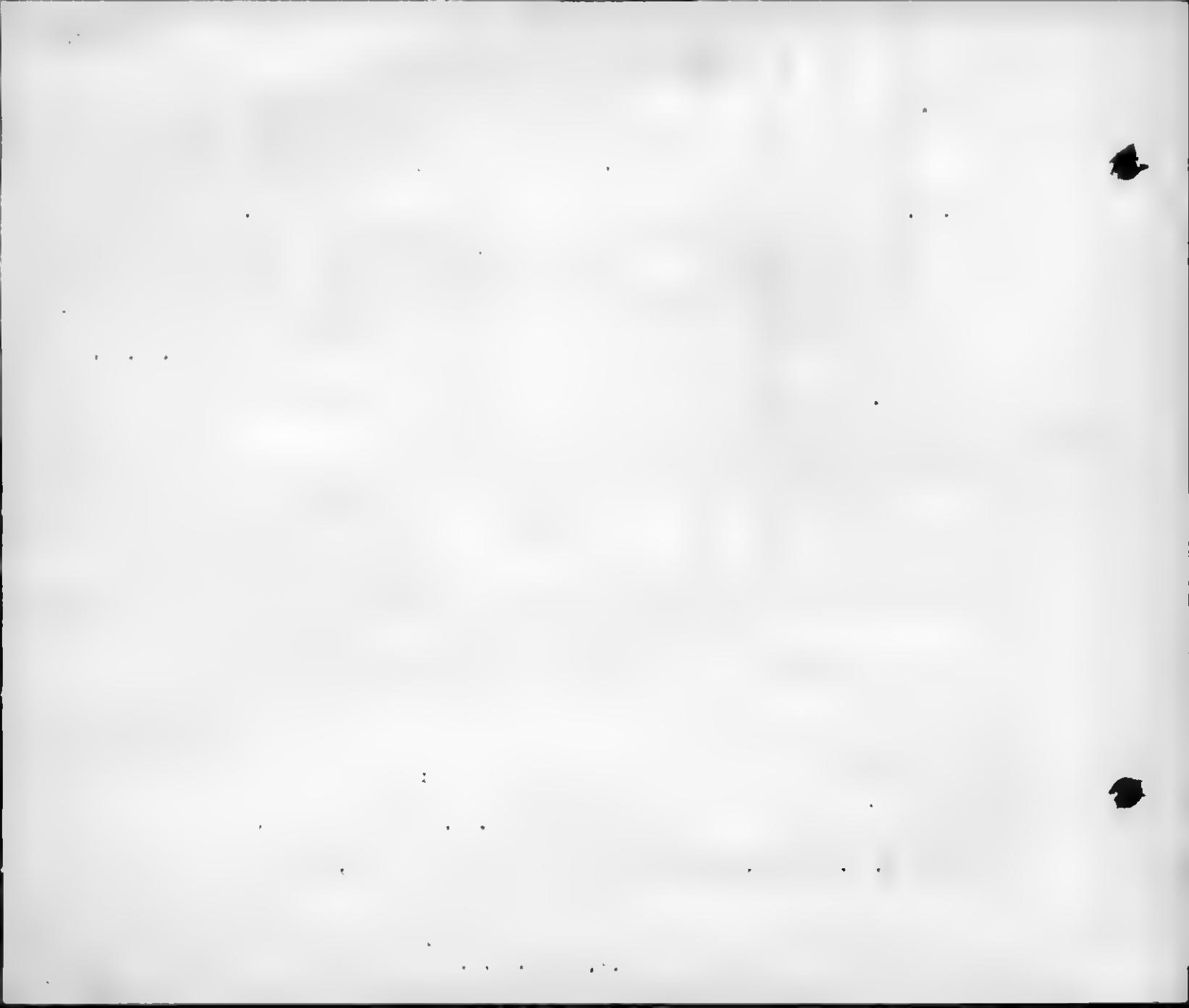
05819

5832 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)	c. LENGTH OF STAY IN lb 9 hrs. 16 min	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	d. STREET ADDRESS 2001 Oglethorpe St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby	First Baby	Middle Boy	Last Pierce		
4. DATE OF DEATH May 21 1959	Month May	Day 21	Year 1959		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH 21 May 1959	9. AGE (In years last birthday) yrs. 9		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Robert L. Peirce		14. MOTHER'S MAIDEN NAME Rose Casterline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO 776x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Prematurity (2 lbs.)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) U. S. Naval Hospital, NINMC	(County) Rockville	(State) Maryland
21. I certify that I attended the deceased from May 21, 1959 , to May 21, 1959 , that I last saw the deceased alive on May 21, 1959 , and that death occurred at 11:53 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NINMC DATE SIGNED 5-21-59					
ACTUAL SIGNATURE <i>H. L. Walton</i>	PHYSICIAN'S NAME (Type) H. L. WALTON, LT MC USN				
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 5-25-59	22c. NAME OF CEMETERY OR CREMATORIUM Parklawn	22d. LOCATION (City, town, or county) Rockville Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Huntemann & Son Funeral Home</i>	ADDRESS 5732 Georgia Ave. N.W. Wash. D.C.	REC'D BY REGISTRAR Orlina S. Krause	24b. REGISTRAR'S SIGNATURE Orlina S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

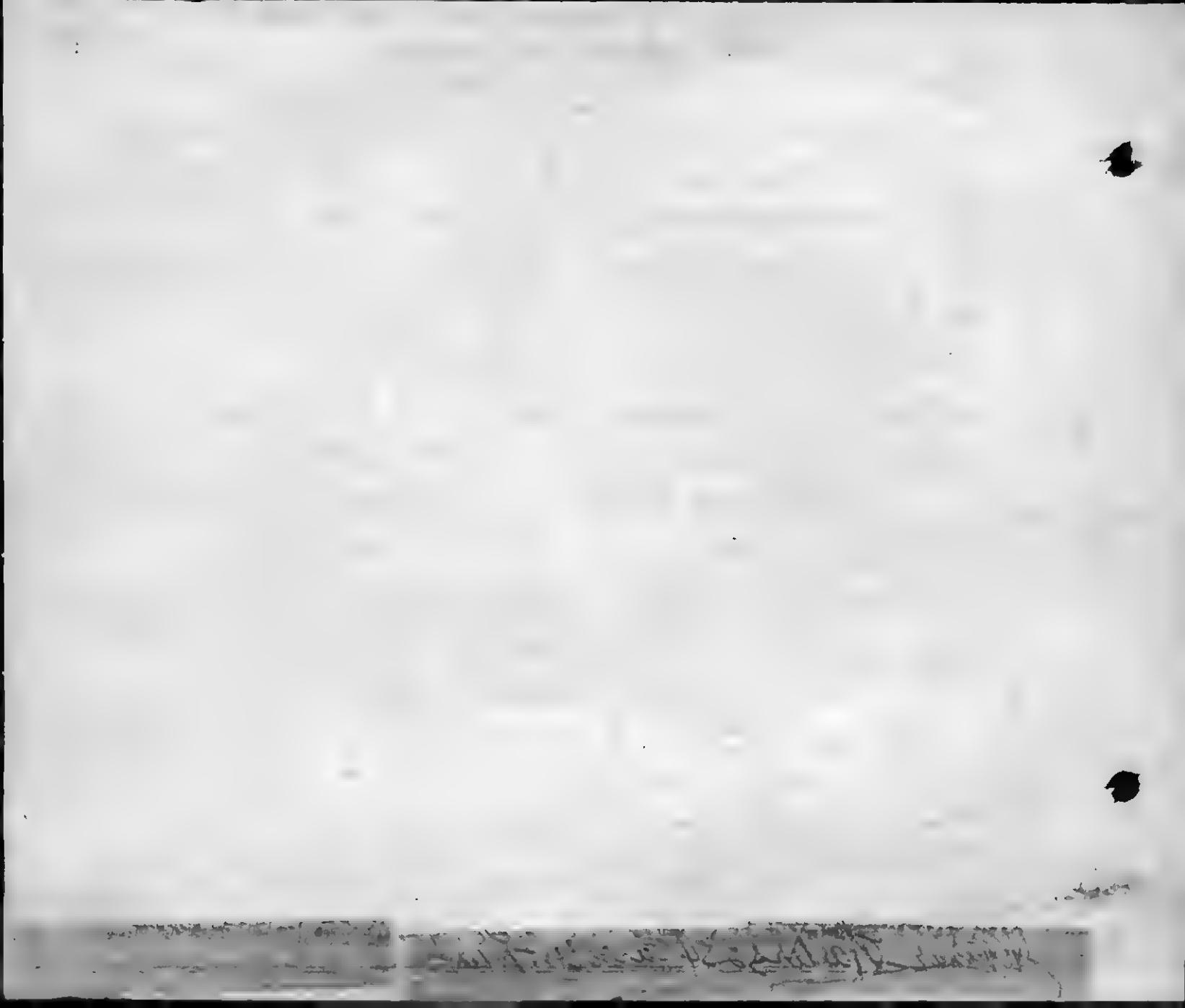
5833

CERTIFICATE OF DEATH

05820

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN lb <i>9 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8910 Bradford Rd.</i>		d. STREET ADDRESS <i>8910 Bradford Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Ada Clara Piper</i>		4. DATE OF DEATH <i>May 21 1959</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 18 1872</i>
9. AGE (In years last birthday) <i>86 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Buena Vista Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Elijah Lee</i>		14. MOTHER'S MAIDEN NAME <i>Susan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Della Twigg</i>		Address <i>8910 Bradford Rd. Silver Spring Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerosis</i>			
DUE TO (b) <i>Old Age</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>February 1959</i> to <i>May 21, 1959</i> that I last saw the deceased alive on <i>May 12, 1959</i> , and that death occurred at <i>11 PM</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>M.D. 10110 Georgia Ave.</i>		DATE SIGNED <i>5/21/59</i>	
ACTUAL SIGNATURE <i>Edward J. Richards</i>		PHYSICIAN'S NAME (Type) <i>EDWARD J. RICHARDS</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/24/58</i>	22c. NAME OF CEMETERY OR CEMETORY <i>GREENHILL CEMETERY</i>	22d. LOCATION (City, town, or county) <i>Buena Vista</i>
22e. FUNERAL DIRECTOR'S SIGNATURE <i>Edward J. Richards</i>	ADDRESS <i>254 Carrollton St. N.W.</i>	24a. REC'D MAY 23 1958	24b. REGISTERED DATE <i>1958</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5834

CERTIFICATE OF DEATH

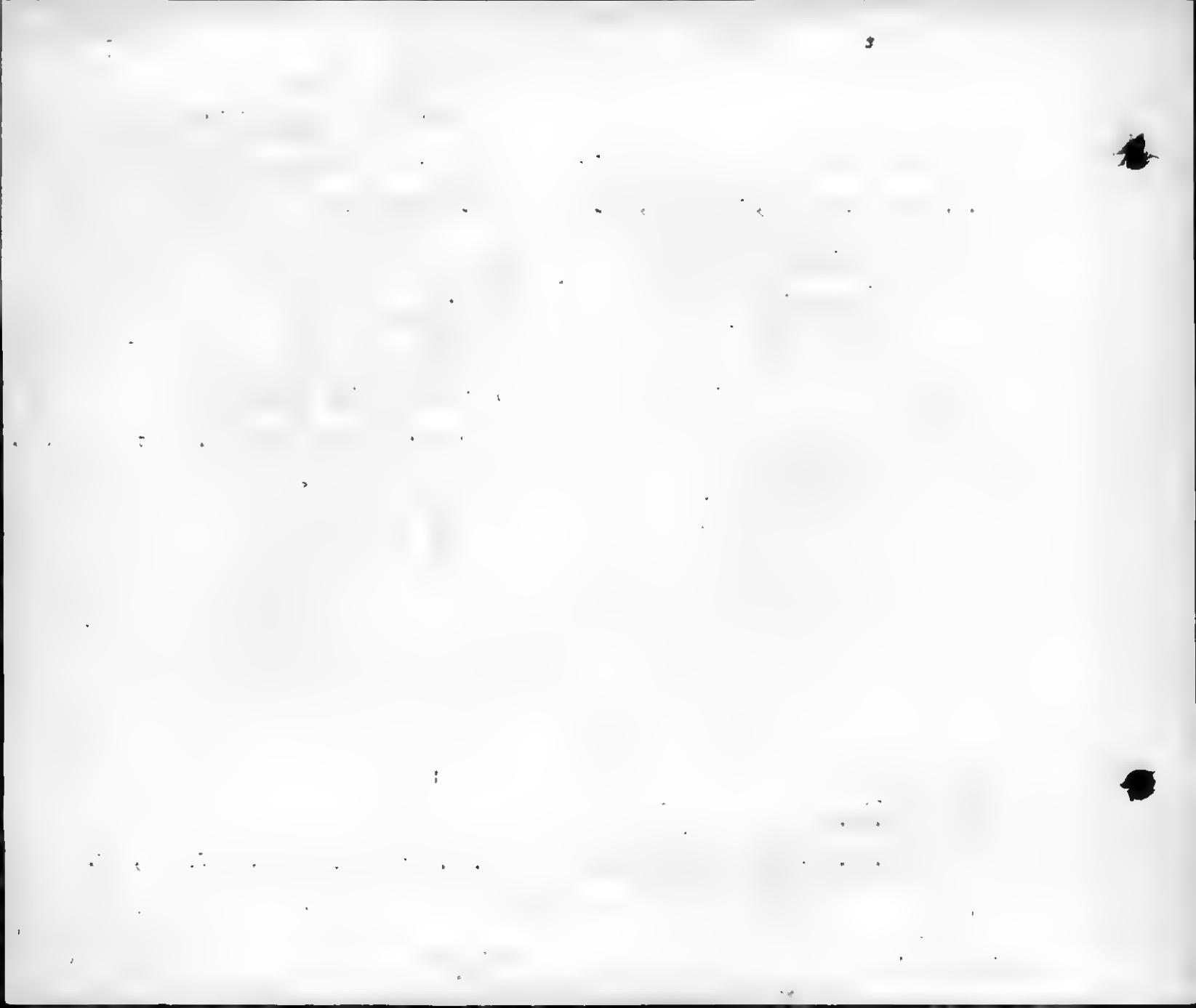
05821

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician

TO FUNERAL DIRECTOR: After this cert. fide has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 2116 Chapman Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Michael Barry POOLE		First	Middle	Last	4. DATE OF DEATH May 24 1959	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-15-54	9. AGE (In years last birthday) 4 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? Canada		
13. FATHER'S NAME William POOLE		14. MOTHER'S MAIDEN NAME Margaret Christina MAC DONALD						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address		
NO				William POOLE 2116 Chapman Dr. Hyattsville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i> aplastic anemia secondary to total body radiation in Rx for terminal lymphatic leukemia</i>								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>body radiation in Rx for terminal</i> (c) <i>lymphatic leukemia</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <i> </i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
19								
21. I certify that I attended the deceased from 23 March 1959 to 24 May 1959 , that I last saw the deceased alive on 24 May 1959 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)							DATE SIGNED	
ACTUAL SIGNATURE <i>H. L. Walton</i>	M.D.							
PHYSICIAN'S NAME (Type) H. L. WALTON	LT MC USN	U. S. NAVAL HOSPITAL, BETHESDA, MD.						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-29-59 (Approx)	22c. NAME OF CEMETERY OR CREMATORIAL Heatherside	22d. LOCATION (City, town, or county) New Glasgow		(State) Novia Scotia			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i>	ADDRESS Funeral Home 7557 Wisconsin Ave Bethesda MD.	24a. REC'D BY REGISTRAR MAY 26 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Turner</i>				



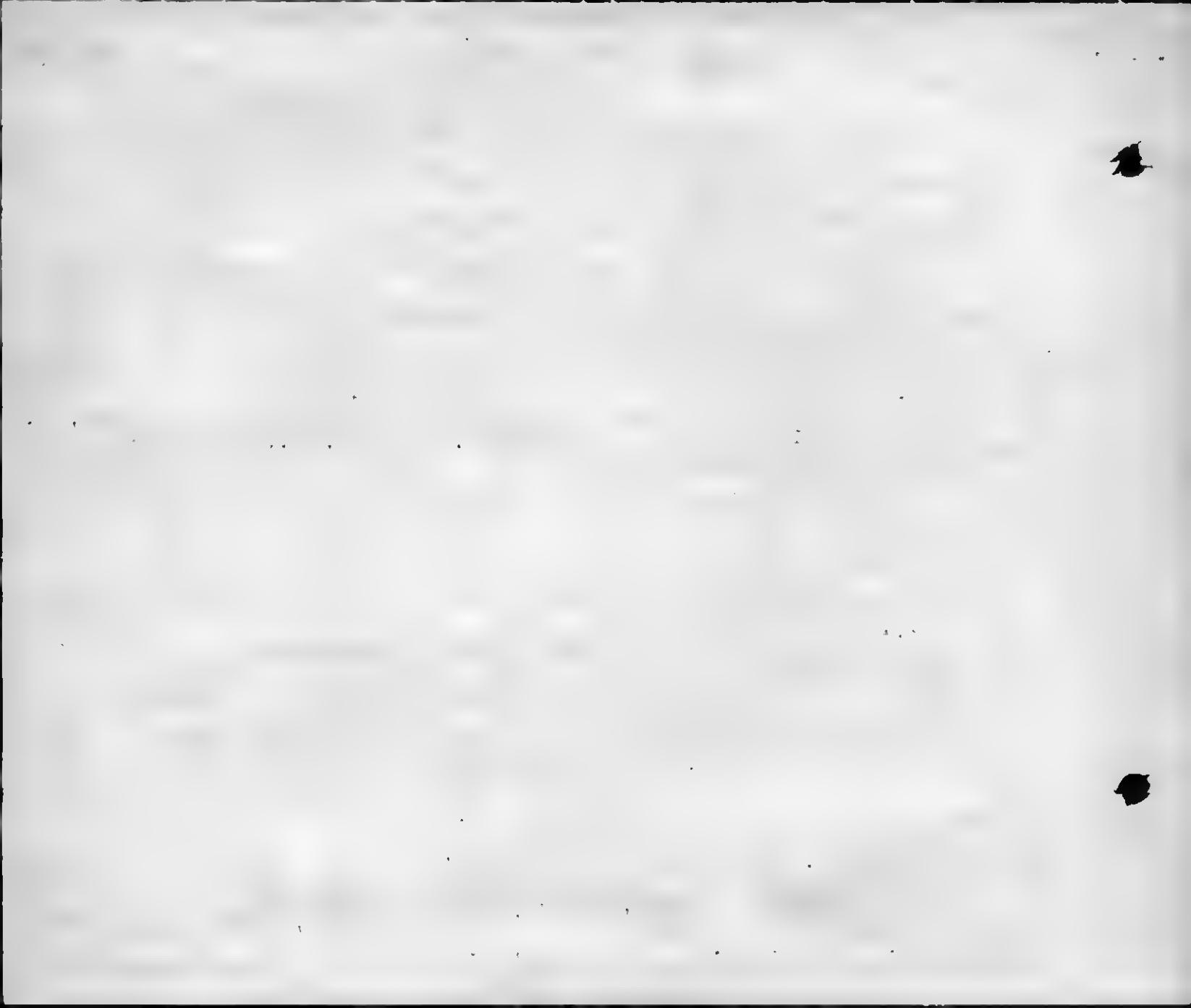
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5720 CERTIFICATE OF DEATH

Reg. Dist. No. 05822

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
c. LENGTH OF STAY IN 1b <i>6 yrs.</i>		d. STREET ADDRESS <i>7402 Garland Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7402 Garland Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Robert Lynton Pritchard</i>		First	Middle
4. DATE OF DEATH <i>May 9</i>		Last	Month
5. SEX <i>M</i>		6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>Feb 18 1901</i>		9. AGE (In years lost birthday) <i>58 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Landscaping</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Landscaping</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>ROBERT W. PRITCHARD</i>		14. MOTHER'S MAIDEN NAME <i>CARRIE B. ALMOND</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, elsewhere) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>577-07-2564</i>	
17. INFORMANT <i>ROBERT L. PRITCHARD, JR., 202 A SOUTH LEE STREET</i>		Address <i>FALLS CHURCH, VA.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Previous Myocardial Infarction 1958</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1958</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7701 Carroll Ave</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1956</i> to <i>May 9 1959</i> that I last saw the deceased alive on <i>May 7 1959</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town/state) <i>7701 Carroll Ave</i> DATE SIGNED <i>5-9-59</i>			
ACTUAL SIGNATURE <i>James M. Whitlock</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>JAMES M. WHITLOCK</i>		ADDRESS <i>Takoma Park Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>5/15/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>BEAHN'S CHAPEL CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>LURAY VIRGINIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR <i>Arthur S. Hause</i>		24b. REGISTRAR'S SIGNATURE	
DATE <i>MAY 18 '59</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Poll 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



X 1
FOR STATE
HEALTH DEPT.

Reg. Dist. No. 05823

TO DEPUTY MEDICAL EXAMINER: This certificate should be within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, and 3 to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

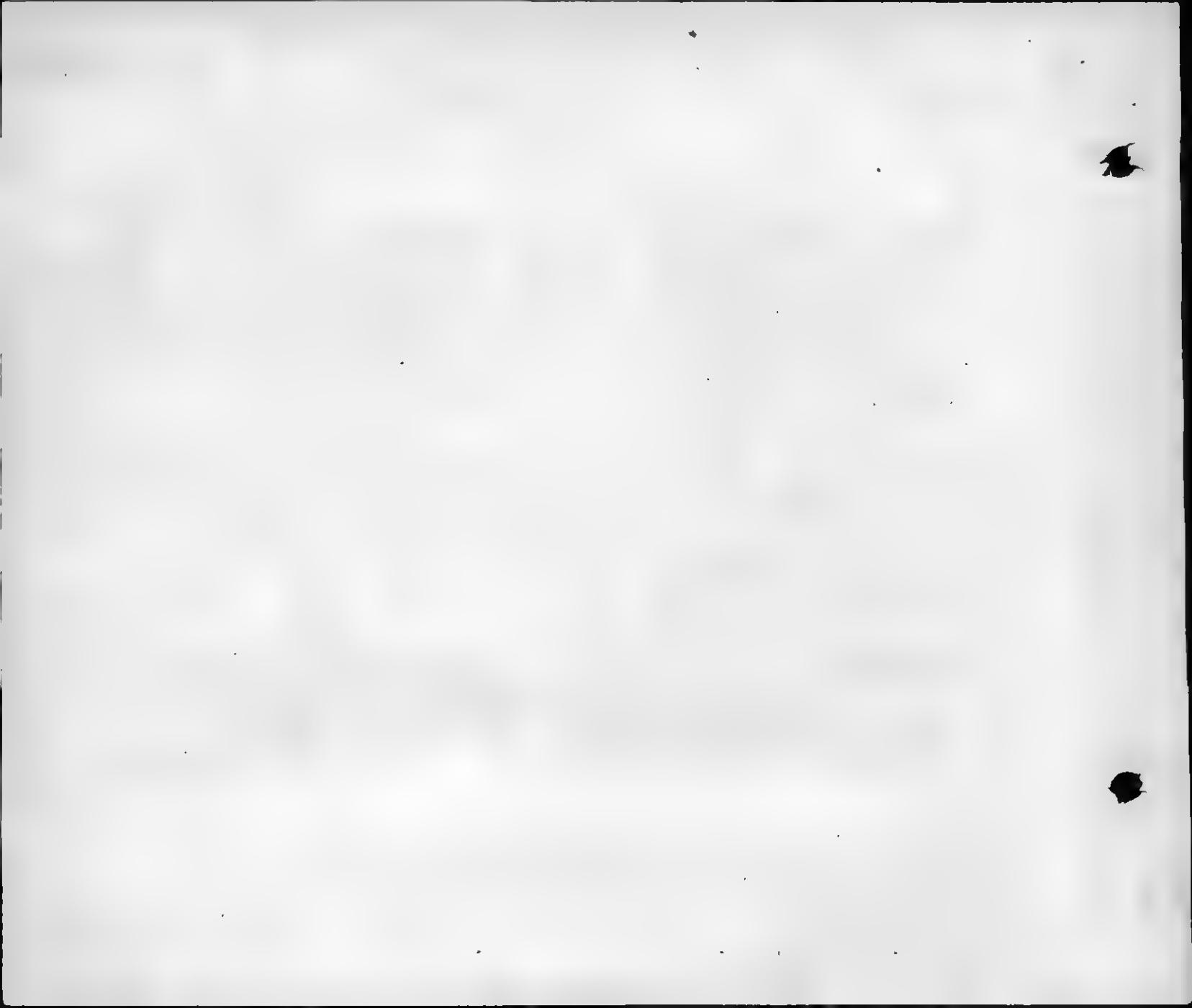
A should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 3 should be a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and my event within 72 hours after death.

X

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>1 1/2 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. STREET ADDRESS <i>4900 Battery Lane</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>4900 Battery Lane</i>				4. DATE OF DEATH Month <i>May</i>		Year <i>30 1959</i>		
5. NAME OF (Type or print) <i>Joseph Newman Parks</i>		First <i>Joseph</i>	Middle <i>Newman</i>	Lost <i>1896</i>	Month <i>May</i>	Day <i>30</i>	Year <i>1959</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-27-1896</i>	9. AGE (In years on birthday) <i>63 yrs</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Attorney (retired)</i>		11. BIRTHPLACE (State or foreign country) <i>D.C.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attorney (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Attorney (retired)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Samuel Byrd Parks</i>		14. MOTHER'S MAIDEN NAME <i>Alice Healey</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO <i>WW #1</i>		17. INFORMANT <i>Geo Bernard Parks</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1. /</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>Hypertension</i> (c)		Address <i>10802 Keller St Silver Spring Md</i> INTERVAL BETWEEN ONSET AND DEATH <i>sudden death</i>
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
20e. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Frank J. Borschke</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>5-30-59</i>		
EXAMINER'S NAME (Type) <i>FRANK J. Borschke</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ARLINGTON NATIONAL CEMETERY</i>		22d. LOCATION (City, town, or county) <i>ARLINGTON, VIRGINIA</i>		(State)		
22b. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <i>BURIAL 6/3/59</i>		22e. ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE JUN 2 '59		24b. REGISTRAR'S SIGNATURE <i>Charles S. Tisdale</i>		
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. <i>Raymond A. Ziska</i>								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5836

CERTIFICATE OF DEATH

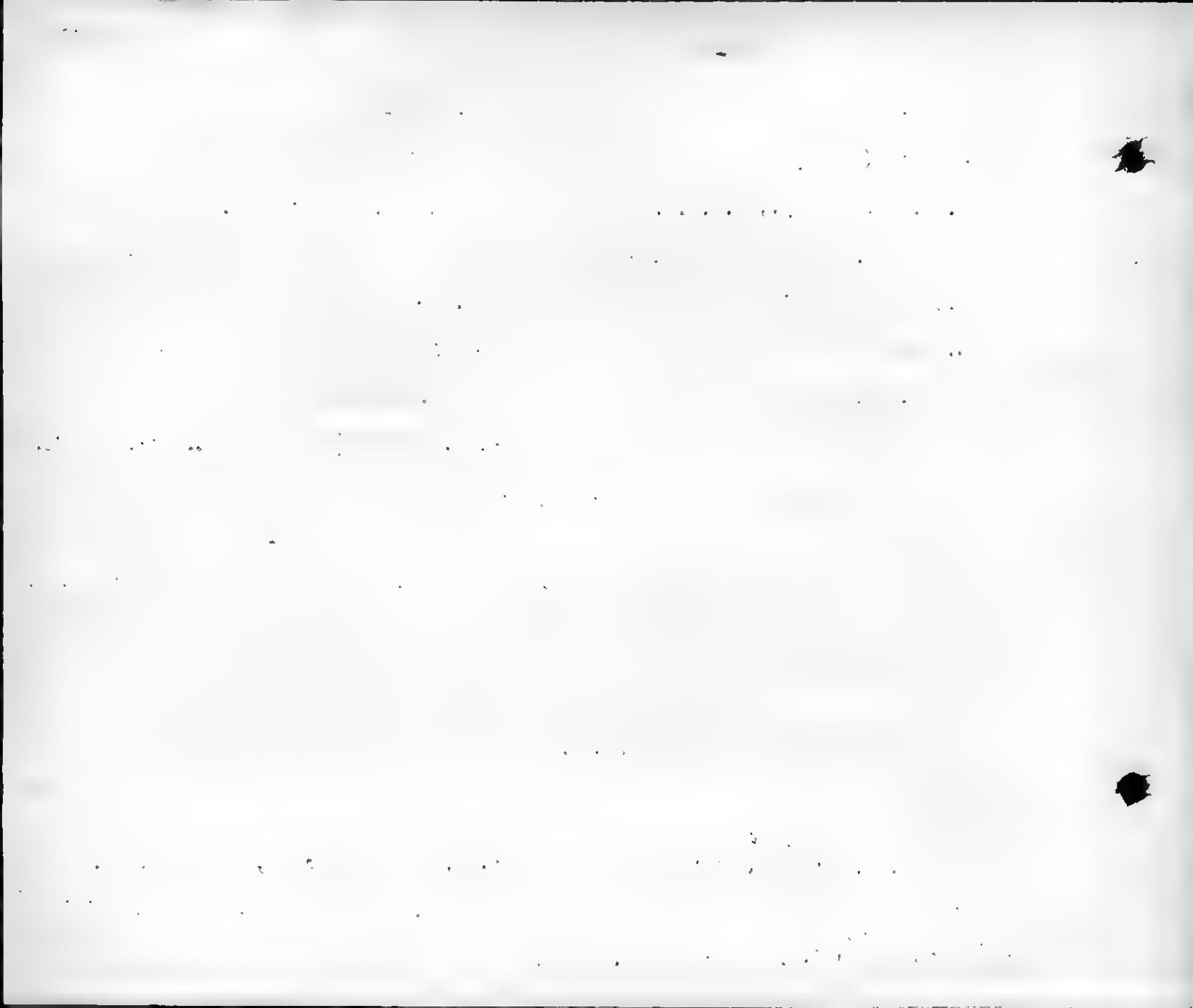
Reg. Dist. No.

05824

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 52 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		d. STREET ADDRESS 3327 S. Stafford St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hosp., N.N.M.C.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Russel	Middle Benjamin	Last PUTNAM	4. DATE OF DEATH	Month May	Day 29	Year 1959
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 7 Jan. 1878	9. AGE (In years from last birthday) 81	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS Hours 0 Min. 0	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. USMC		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. PUTNAM				14. MOTHER'S MAIDEN NAME Mary P. JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW-1	17. INFORMANT Mabel T. PUTNAM (wife)	Address 3327 S. Stafford St.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO 420.1 INTERVAL BETWEEN ONSET AND DEATH 3 hours							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) Myocardial infarction DUE TO 48 hours							
DUE TO (c) Arterosclerosis, generalized DUE TO 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Apr. 1959 to 27 May 1959 , that I last saw the deceased alive on 29 May 1959 , and that death occurred at 1838B , from the causes and on the date stated above							
ADDRESS (Street, city or town, state) U. S. Naval Hospital, Bethesda, Md. DATE SIGNED							
ACTUAL SIGNATURE J. M. Young M.D.							
PHYSICIAN'S NAME (Type) J. M. YOUNG LT MC USN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-2-59	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cem.			22d. LOCATION (City, town, or county) Arlington, Virginia (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons				ADDRESS 1756 Penn. Ave WDC		24a. REC'D BY REGISTRAR JUN 3 1959	24b. REGISTRAR'S SIGNATURE Arthur J. ...



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05825

5837 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2230 California St., N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 2230 California St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First William	Middle Satterlee	Last PYE	4. DATE OF DEATH May 4 1959	Month May	Day 4	Year 1959
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5. SEX Male	6. COLOR OR RACE Cuacasion	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-80	9. AGE (In years last birthday) 78 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner	10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	11. BIRTHPLACE (State or foreign country) Minnesota	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME James PYE	14. MOTHER'S MAIDEN NAME Clara SATTERLEE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 1896 to 1944	17. INFORMANT Hospital Records	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Liver Failure Carcinomatosis, abdominal, origin undf. 4 months		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) carcinomatosis, liver, 4 months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
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20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from March 31, 1959, to May 4, 1959, that I last saw the deceased alive on May 4, 1959, and that death occurred at 8:20 P.M., from the causes and on the date stated above.			
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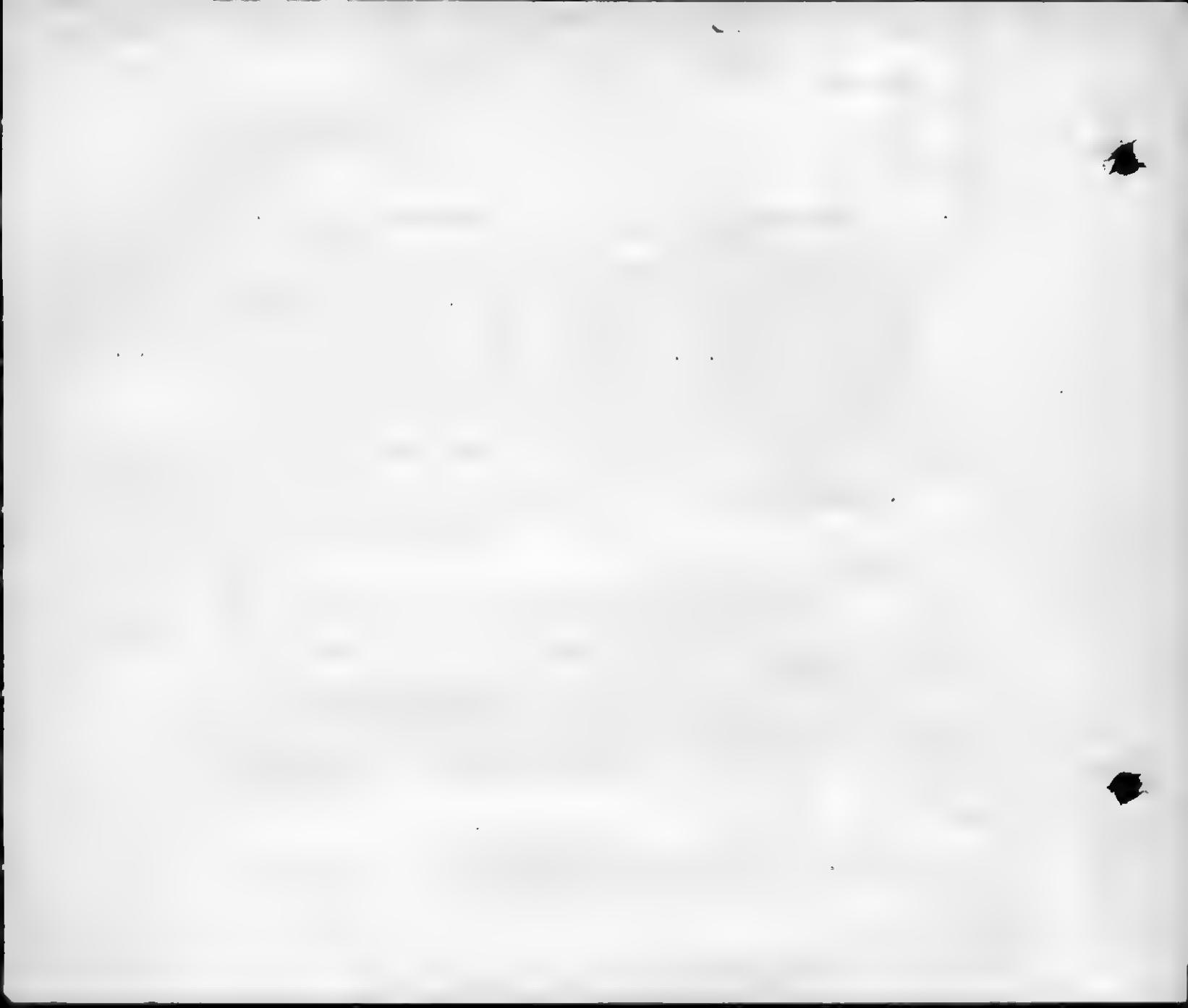
ACTUAL SIGNATURE H. E. Richardson, M.D.	ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC	DATE SIGNED 5-5-59
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PHYSICIAN'S NAME (Type) H. E. RICHARDSON, CAPT, MC, USN	Bethesda 14, Maryland		
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-8-59	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National	22d. LOCATION (City, town, or county) Arlington	(State) Virginia
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23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey	ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.	24a. REC'D BY REGISTRAR DATE MAY 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

5838

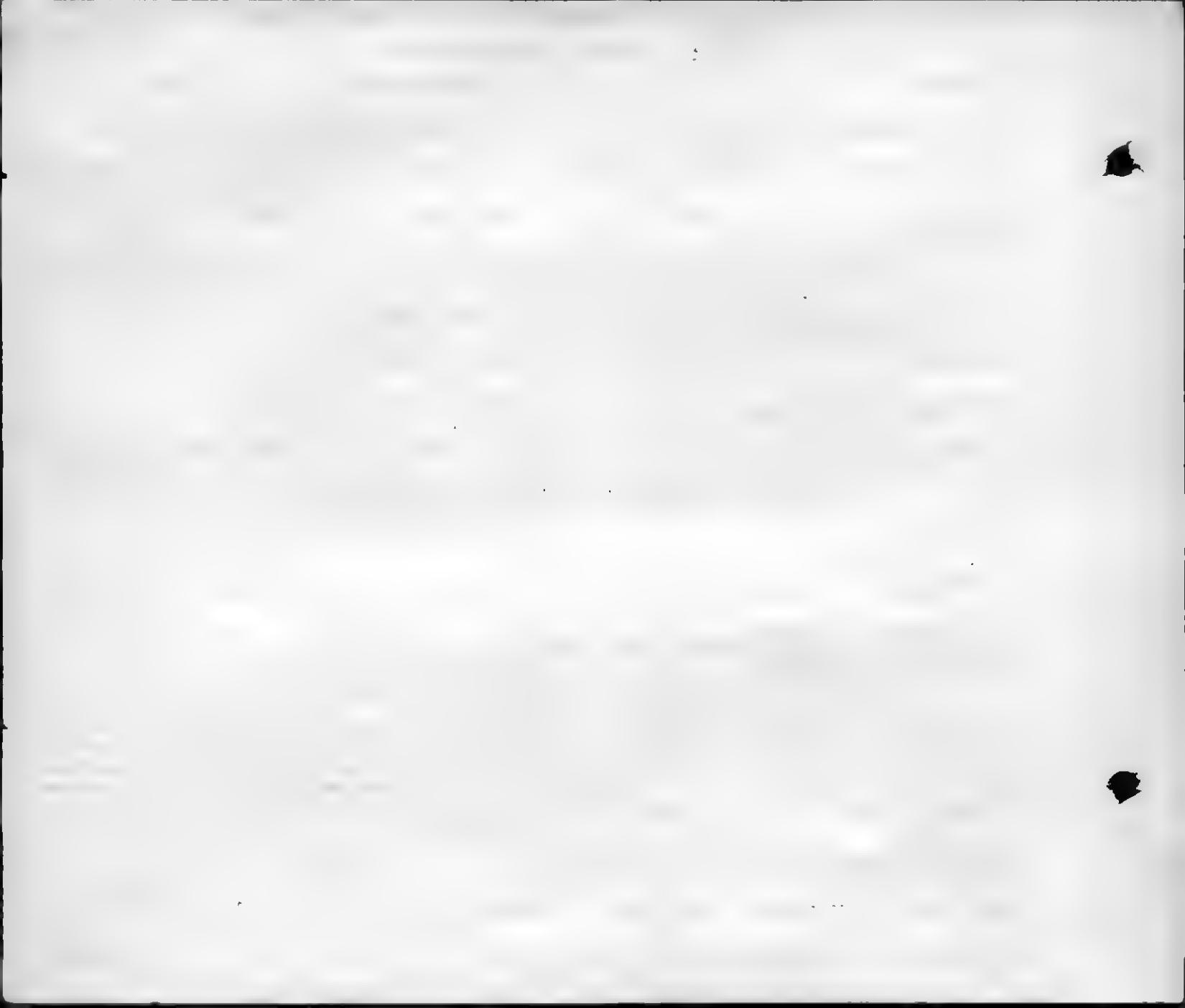
CERTIFICATE OF DEATH

Reg. Dist. No.

05826

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>District of Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>30 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Resmer Sanitarium Bethesda</i>		5721 Grosvenor Lane		d. STREET ADDRESS <i>2231 California St. N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>Frances Happerset Rees</i>		First <i>Frances</i>	Middle <i>Happerset</i>	Last <i>Rees</i>	4. DATE OF DEATH <i>MAY 5 1959</i>
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>31 October 1899</i>		9. AGE (In years last birthday) <i>59 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerical</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Government</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
13. FATHER'S NAME <i>Thomas Henry Rees</i>		14. MOTHER'S MAIDEN NAME <i>Frances Happerset</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>10</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>(Sister) Mrs. Dorothy Crowley, Wash. D.C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Adenocarcinoma of Lung</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 mo.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), listing the under- lying cause last. <i>(b)</i>					
DUE TO <i>(c)</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour <i>5 55</i> p. m.		Month <i>5</i>	Day <i>5</i>	Year <i>1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>4-5</i> , 19 <i>59</i> , to <i>5-5</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5-3</i> , 19 <i>59</i> , and that death occurred at <i>5:55</i> AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Levone H. Epstein</i>		ADDRESS (Street, city or town, state) <i>2025 Eye St., N.W., Wash. D.C.</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Levone Epstein</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-7-1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i>	
22d. LOCATION (City, town, or county) <i>Fort Myer, Virginia</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Hawley Sons</i>		ADDRESS <i>1756 Pa. Av. 71.W.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 7 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arline & Thorne</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05827

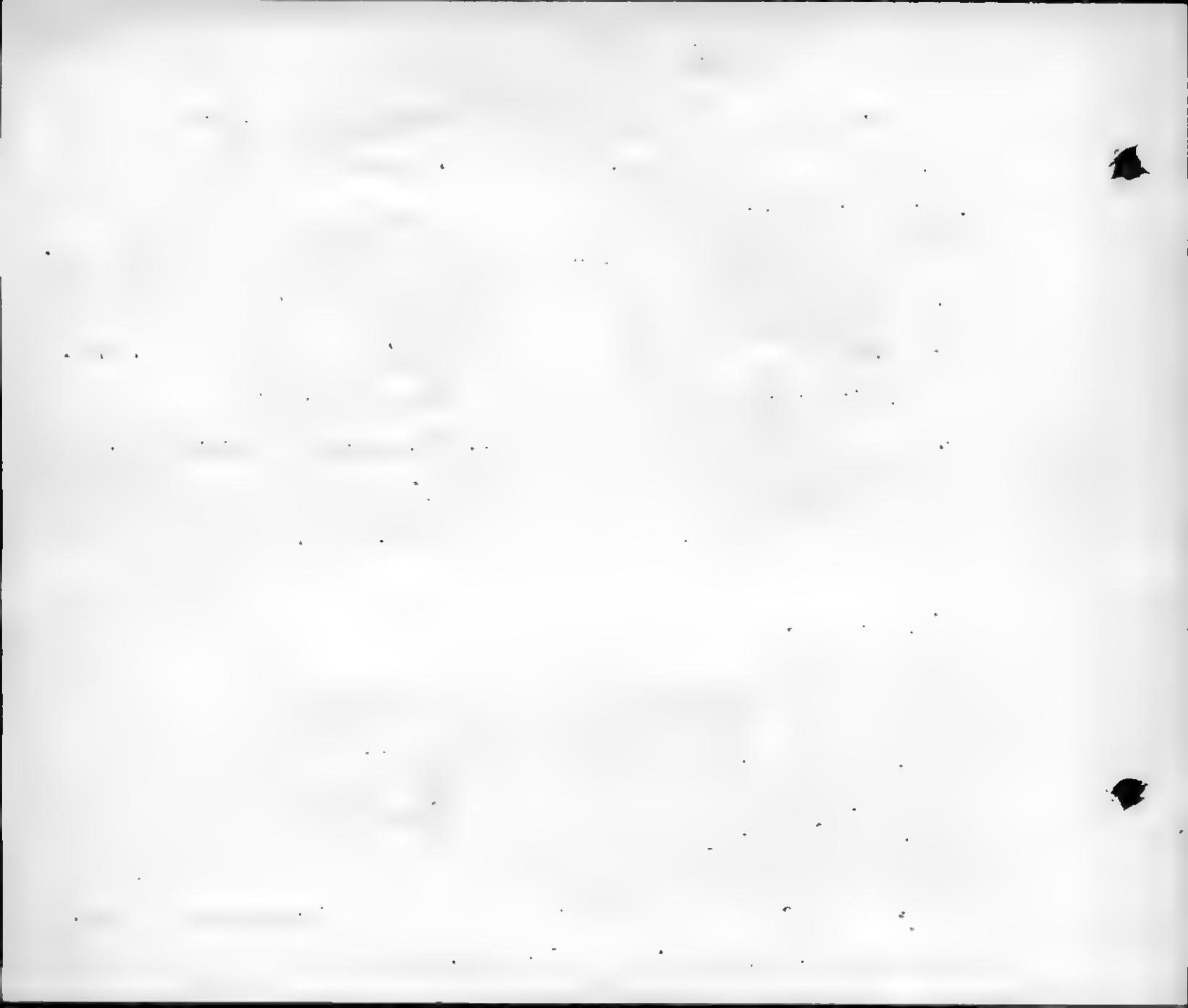
5839 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buck Lodge		c. LENGTH OF STAY IN 1b 1 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simpson Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clinton Monroe Rhodes		4. DATE OF DEATH 5 20 1959	Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christian Rhodes		14. MOTHER'S MAIDEN NAME Catherine Buzzard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Flora Rhodes		Address Dickerson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, Acute, 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized Arteriosclerosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			
19. WAS ANATOMICAL EXAMINATION PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)	
21. I certify that I attended the deceased from March, 1959 to 20 May, 1959 that I last saw the deceased alive on 20 May, 1959 and that death occurred at 10:51 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 21 May 59			
ACTUAL SIGNATURE <i>John M. Smith</i>		PHYSICIAN'S NAME (Type) Monocacy	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/59	
22c. NAME OF CEMETERY OR CREMATORIUM Monocacy		22d. LOCATION (City, town, or county) Beallsville (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		ADDRESS Barnesville, Md.	
24a. REC'D BY REGISTRAR MAY 25 '59		24b. REGISTRAR'S SIGNATURE Carroll & Sons	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5721 CERTIFICATE OF DEATH

05828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON IV SANITARIUM		e. STREET ADDRESS 14 MANCHESTER PLACE	
3. NAME OF DECEASED (Type or print) HARRY JOSEPH RITER		4. DATE OF DEATH HAY 22 1959	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY SHOES	
11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LOUIS RITER		14. MOTHER'S MAIDEN NAME IDA SCHWARTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW II		16. SOCIAL SECURITY NO 17. INFORMANT LOUIS WAYMAN Address 5581-CHILLUM PL NE WASHINGTON 11, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 4 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 1 1959 to MAY 22 1959 that I last saw the deceased alive on MAY 22 1959 , and that death occurred at 9:15 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Samuel J N Siegel M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Samuel J N Siegel DATE SIGNED 4300 Kaywood Drive NAV 22, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-26-59	
22c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NAT CEM.		22d. LOCATION (City, town or county) ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Dangani Rayamji		24a. REC'D BY REGISTRAR DATE MAY 26 '59	
ADDRESS 3501-14 St NW		24b. REGISTRAR'S SIGNATURE C. L. Kraus	



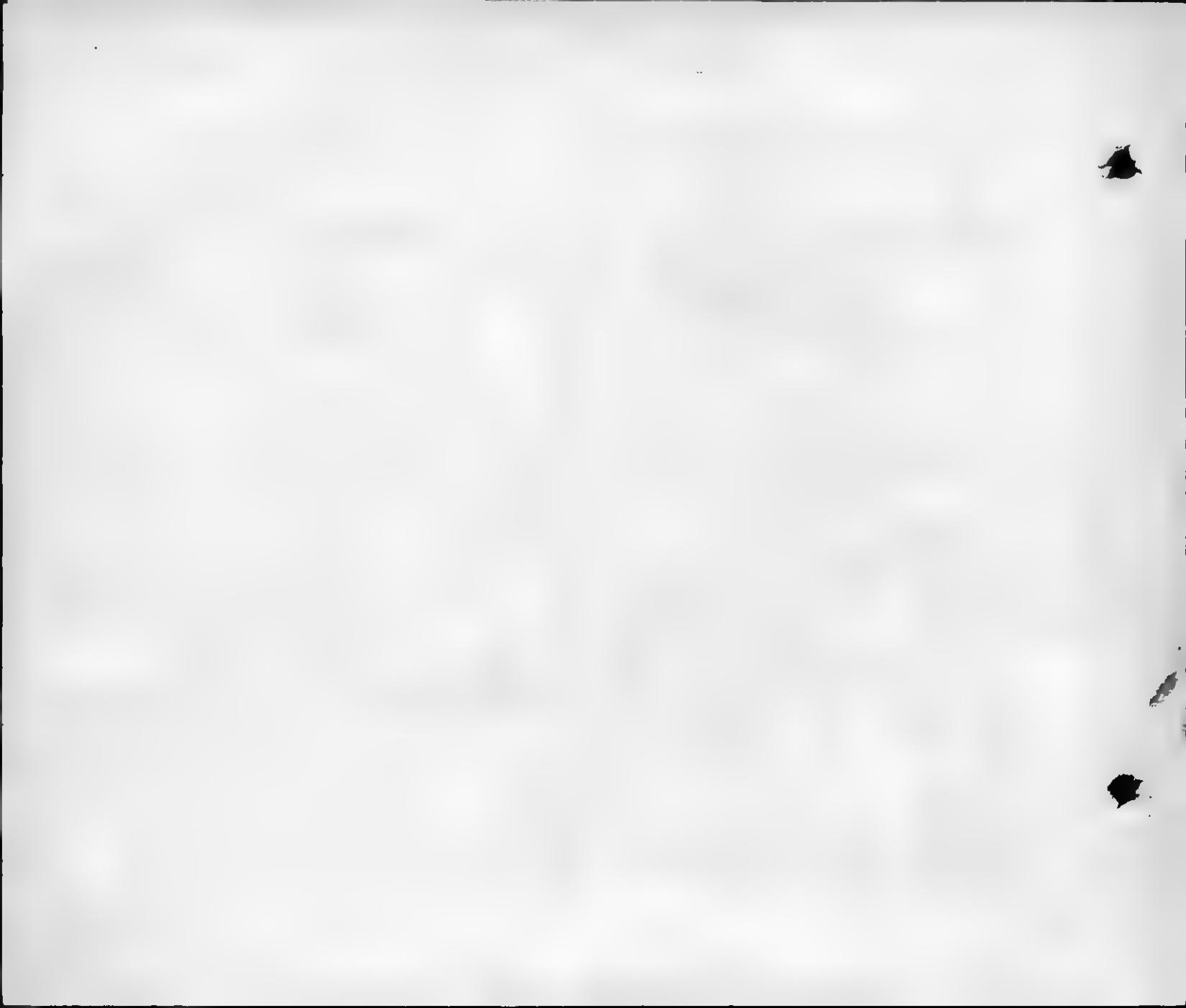
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05829

5840 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>District of Columbia</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>7 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C. 47x.5</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Resmor Sanitarium</i>		d. STREET ADDRESS <i>7705 Morningside Drive NW</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Elsie</i>	Middle <i>Shields</i>	Last <i>Robinson</i>	4. DATE OF DEATH <i>26 Feb. 1873</i>	Month Day Year <i>May 6 1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>86 yrs.</i>	9. AGE (In years last birthday) yrs. Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>District of Columbia</i>	12. CITIZEN OF WHAT COUNTRY? <i>District of Columbia</i>
13. FATHER'S NAME <i>Samuel Shields</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Niece, Mrs. James H. Rees</i>	Address <i>7705 Morningside</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Coronary Artery Occlusion		INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>				
		Coronary Artery Sclerosis		years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fracture right hip - operated - Feb 27, 1959</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Fracture right hip - operated - Feb 27, 1959</i>						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>5516 Neb. Acre</i>	(County) <i>5-6-59</i>	(State)	
21. I certify that I attended the deceased from <i>May 2, 1959</i> to <i>May 6, 1959</i> , that I last saw the deceased alive on <i>May 2, 1959</i> , and that death occurred at <i>4:20 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert B. Havell</i> M.D. <i>5516 Neb. Acre, 5-6-59</i> PHYSICIAN'S NAME (Type) <i>Robert B. Havell</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremated</i>		22b. DATE THEREOF <i>May 4-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Crematorium</i>		22d. LOCATION (City, town, or county) <i>5516 Neb. Acre</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur & Krause</i>		ADDRESS <i>1667 Galt Hwy</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 11 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur & Krause</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

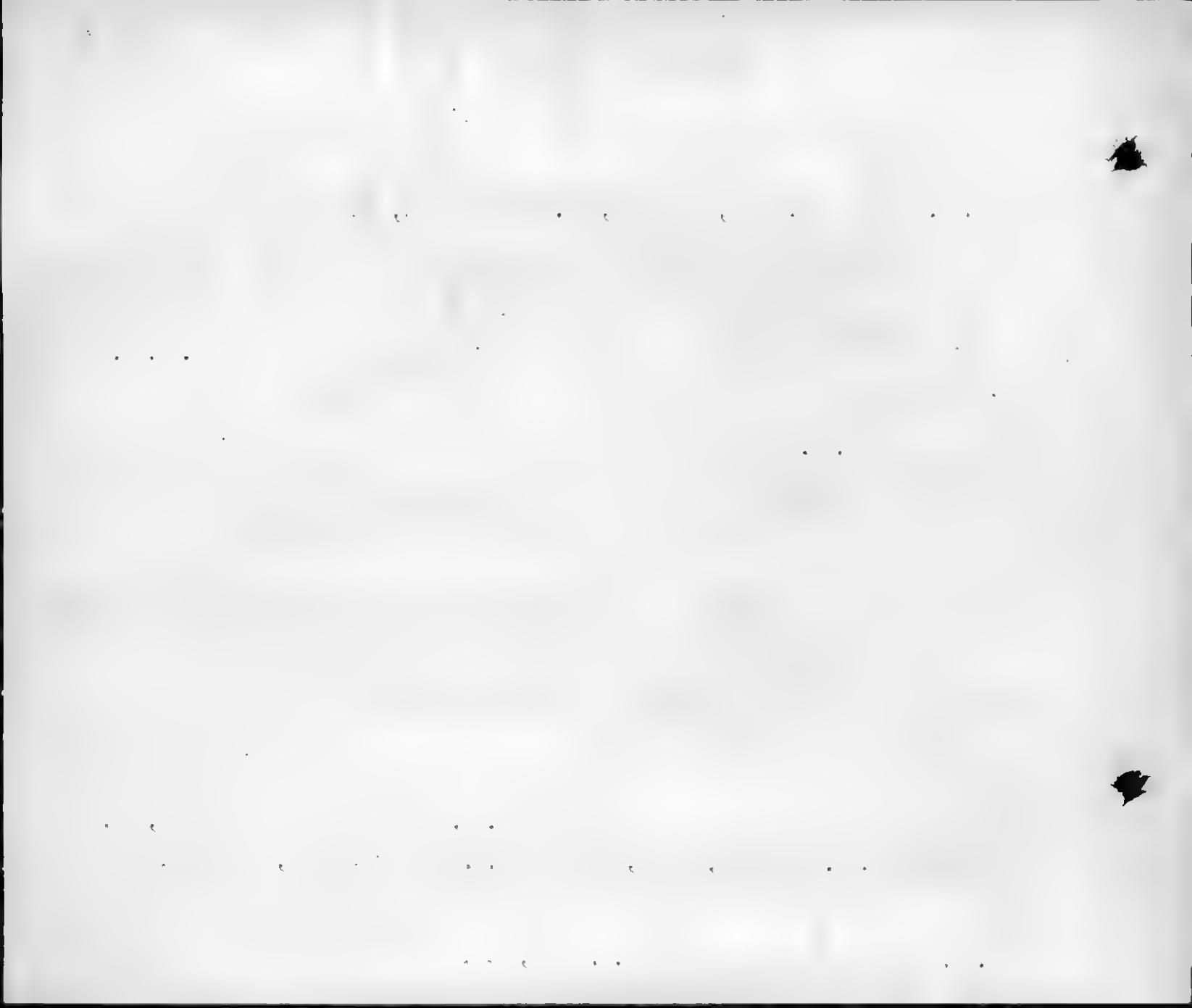
5841 CERTIFICATE OF DEATH

05830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY Stafford (City)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stafford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hosp. NNMC, Bethesda, Md.		d. STREET ADDRESS RFD #4, Box 339	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Edward	Last ROLLINS
4. DATE OF DEATH	Month May	Day 24	Year 19 59
5. SEX Male	6. COLOR OR RACE Negroid	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-87
9. AGE (in years last birthday) 71 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Simond ROLLINS	14. MOTHER'S MAIDEN NAME Susan Ann WHITE	15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] <input checked="" type="checkbox"/> Yes U. S. Army	
16. SOCIAL SECURITY NO.		17. INFORMANT	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE (UREMIA)</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u> 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <u>CHRONIC BILATERAL NEPHROSCLEROSIS</u> 10 YEARS DUE TO (c) <u>CHRONIC INFECTION AND HYPERTENSION</u> 10 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTERIOSCLEROTIC HEART DISEASE & CONGESTIVE FAILURE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED (Enter name of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11 May</u> , 19 <u>59</u> , to <u>24 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>24 May</u> , 19 <u>59</u> , and that death occurred at <u>0333 A.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>F. S. Caldwell</u> ADDRESS (Street, city or town, state) DATE SIGNED M.D. U. S. NAVAL HOSPITAL, BETHESDA, MD.			
PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT MC, USN	U.S. NAVAL HOSPITAL, BETHESDA, MD		
22a. BURIAL/CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-26-59	22c. NAME OF CEMETERY OR CREMATORIUM UNIONVILLE CEMETERY	22d. LOCATION (City, town, or county) STAFFORD (State) VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE W. E. JARVIS 1432 "U" STREET N.W. WASH, D.C.	ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 26 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

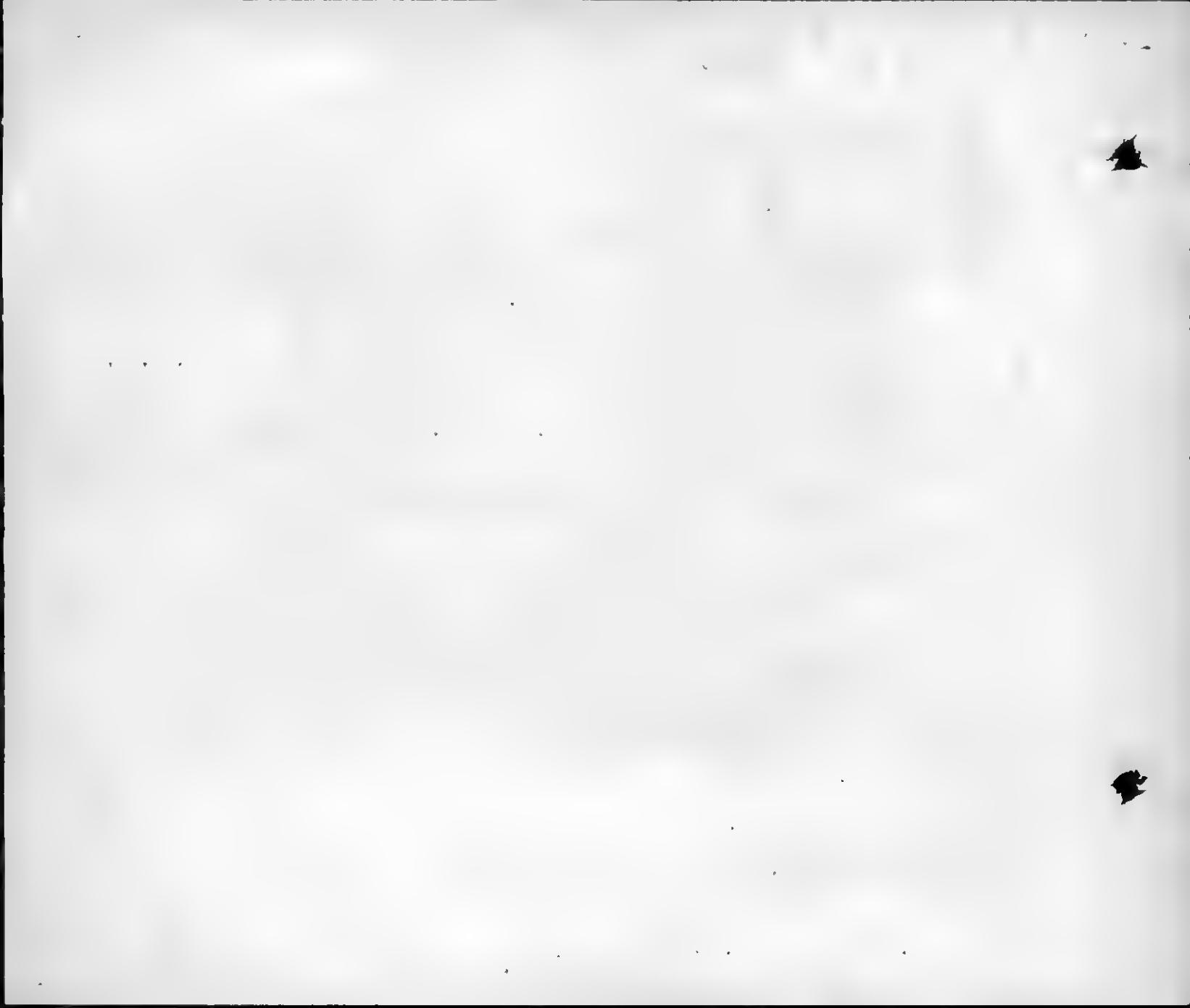
5842 CERTIFICATE OF DEATH

05831

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Montgomery</i>		b. COUNTY <i>MONTGOMERY</i>	
c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Montgomery County</i>		d. STREET ADDRESS <i>1522 LIVE OAK DRIVE</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Julia</i>	Middle <i>ANNA</i>	Last <i>Russell</i>
4. DATE OF DEATH	Month <i>5</i>	Day <i>31</i>	Year <i>1959</i>
S. SEX <i>Fe</i>	COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/20/73</i>
9. AGE (In years last birthday) <i>86 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (State or foreign country) <i>Austria</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Valentine Makre</i>	14. MOTHER'S MAIDEN NAME <i>Frances Hans</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>no</i>	16. SOCIAL SECURITY NO <i>none</i>	INFORMANT <i>Mrs. Jesse M. Eader</i>	Address <i>1522 Live Oak Drive, Silver Spring, Maryland</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>351X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Hypertension</i> DUE TO (c) <i>Atherosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>3-4 d.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct</i> , 1958 to <i>31 May</i> , 1959, that I last saw the deceased alive on <i>30 May</i> , 1959, and that death occurred at <i>9:42 AM</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>William D. Aud</i> M.D. PHYSICIAN'S NAME (Type) <i>WILLIAM D. AUD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/3/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>New Cathedral Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Zink</i>	ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>	24a. REC'D BY REGISTRAR <i>JUN 2 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
VS A15 (4) 1SM 10/57			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

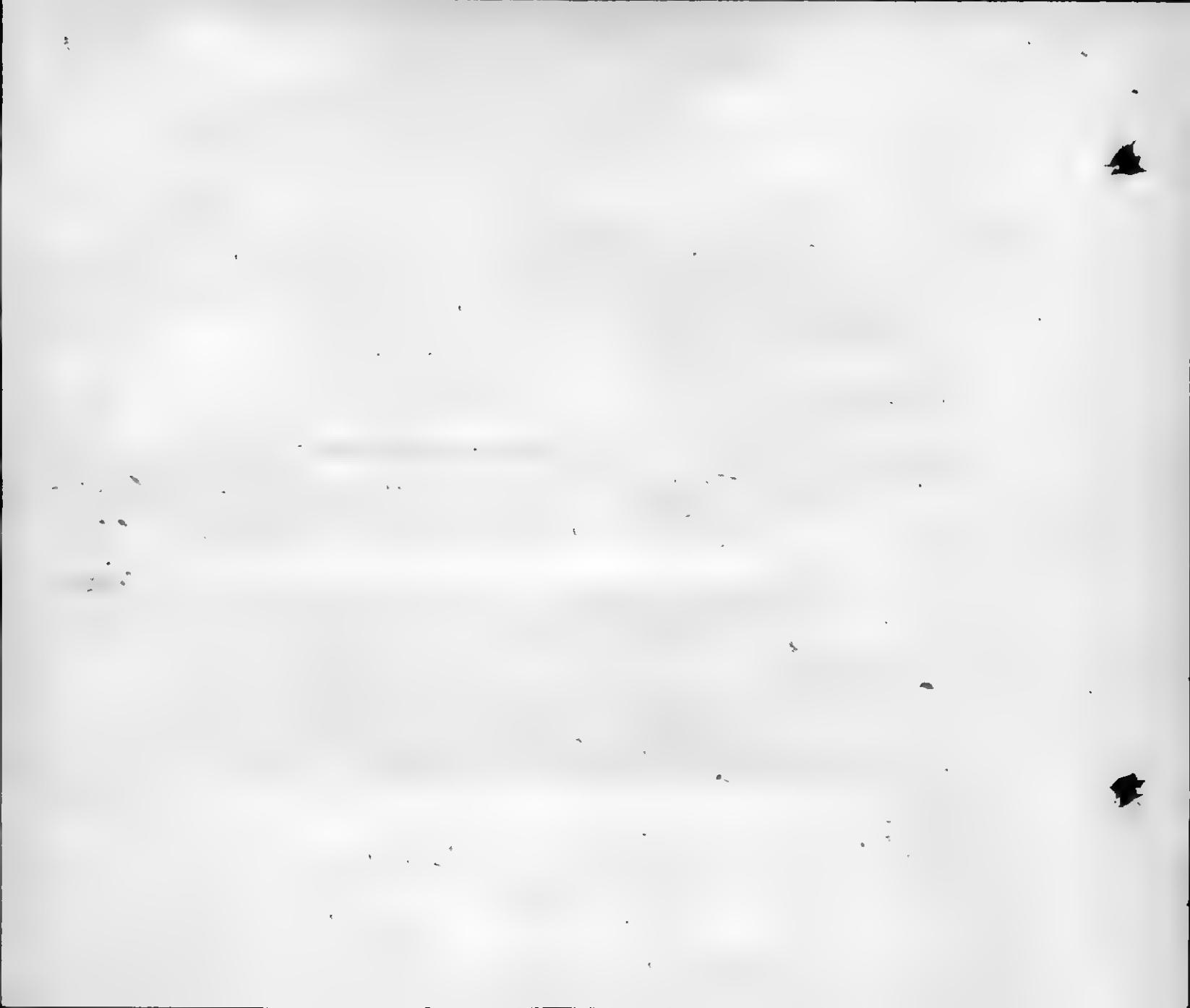
5843

CERTIFICATE OF DEATH

05832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6206 Western Avenue		d. STREET ADDRESS / 6406 Western Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ELIZABETH M. SCHLAUDECKER		First	Middle	Last	4. DATE OF DEATH May 31,	Month	Day	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 89 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 18	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Erie. Pa.		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Frank Heg Hoffmann		14. MOTHER'S MAIDEN NAME Kathryn ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John A. Schlaudecker-Item # 2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH Myocardial Insufficiency of the Orteas rarerote Heart Disease 10 yr -				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus - 18 yr -						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5522 Western ave		20f. (City or town) Erie, Pennsylvania		(County) (State)
21. I certify that I attended the deceased from alive at <u>30 May 1959</u> , 1959, to <u>31 May 1959</u> , that I last saw the deceased and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE P.H. Richwine		M.D.		ADDRESS (Street, city or town, state) 5522 Western ave		DATE SIGNED		
PHYSICIAN'S NAME (Type) A.H. Richwine								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/59		22c. NAME OF CEMETERY OR CREMATORIAL Trinity		22d. LOCATION (City, town, or county) Erie, Pennsylvania		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 2 '59		24b. REGISTRAR'S SIGNATURE Clyburn S. Tamm		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

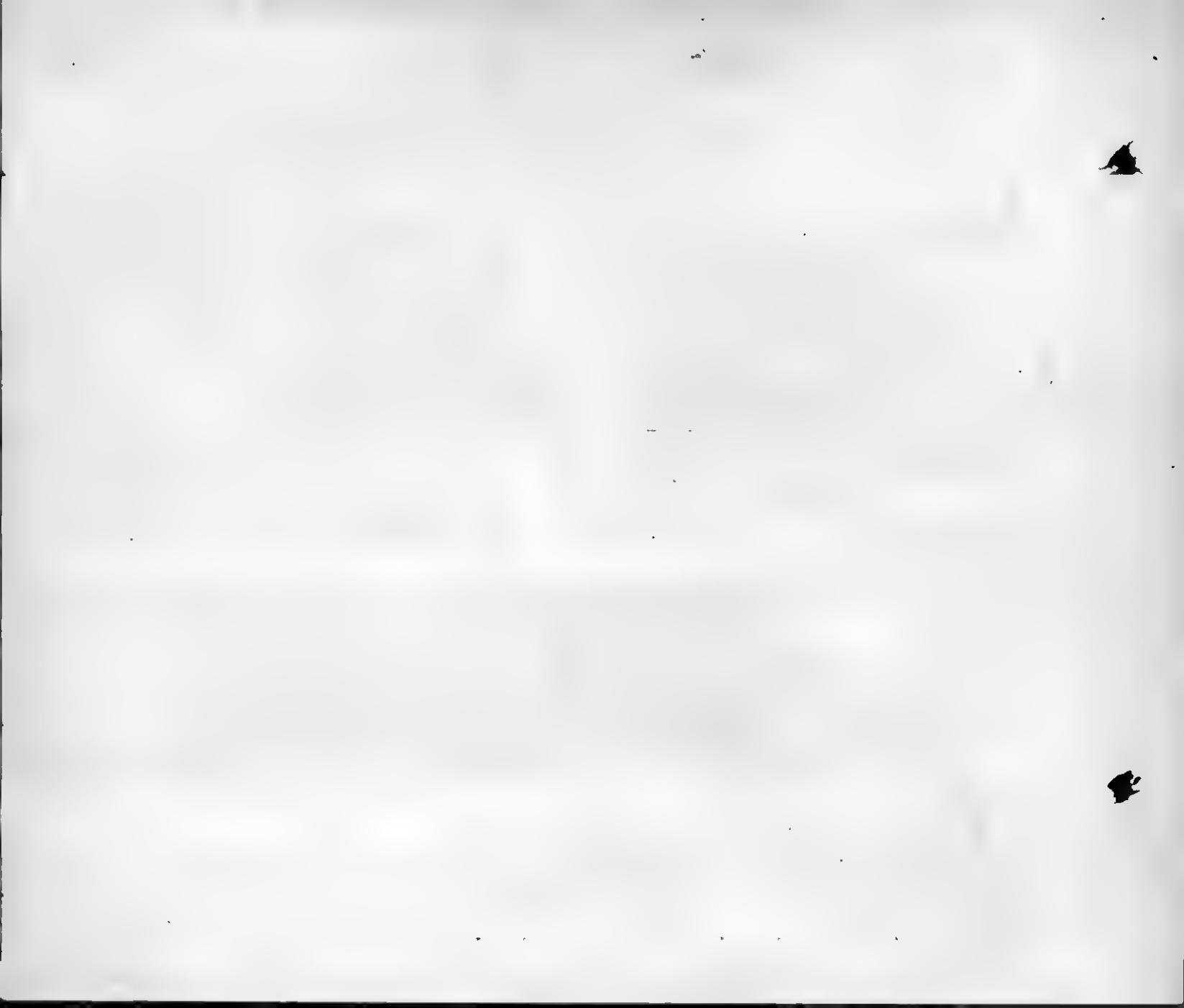
5722

CERTIFICATE OF DEATH

Reg. Dist. No. 05833

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>12 1/2 hrs.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>60 University Blvd. E.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Clelia Regina Schielle</i>		First	Middle	Last	4. DATE OF DEATH <i>5 - 16 1959</i>	Month	Day	Year		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-6-21</i>	9. AGE (In years last birthday) <i>37</i>	IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS. Days <i>16</i>	Hours <i>00</i>	Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>W. Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>				
13. FATHER'S NAME <i>Homer BURKHAMMER</i>		14. MOTHER'S MAIDEN NAME <i>Florence Turner</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>168-20-4982</i>				17. INFORMANT <i>Hospital Records.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>155.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Carcinoma - metast. prob. in CNS		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>		Carcinoma of Colon				<i>2 mo.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1600 Carroll Ave.</i>		20f. (City or town) <i>Takoma Park</i>		(County) <i>12, Md.</i>	(State) <i>MD</i>	
21. I certify that I attended the deceased from <i>Oct. 12, 1959</i> to <i>16 May, 1959</i> , that I last saw the deceased alive on <i>15 May, 1959</i> , and that death occurred at <i>12:30 A.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>1600 Carroll Ave., MD</i>				DATE SIGNED <i>5/16/59</i>
ACTUAL SIGNATURE <i>W.P. McNeilly, M.D.</i>										
PHYSICIAN'S NAME (Type) <i>W.P. McNeilly, M.D.</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL <i>5/19/59</i>		22b. DATE THEREOF <i>5/19/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ARLINGTON NATIONAL CEMETERY</i>		22d. LOCATION (City, town, or county) <i>ARLINGTON, VIRGINIA</i>		(State) <i>VA</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 19 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur & Hause</i>				



TO DEPUTY MEDICAL EXAMINER: This certificate should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 3 should be forwarded to the Funeral Director. Page 3 should be used as a burial-trust permit. File Pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE
HEALTH DEPT.

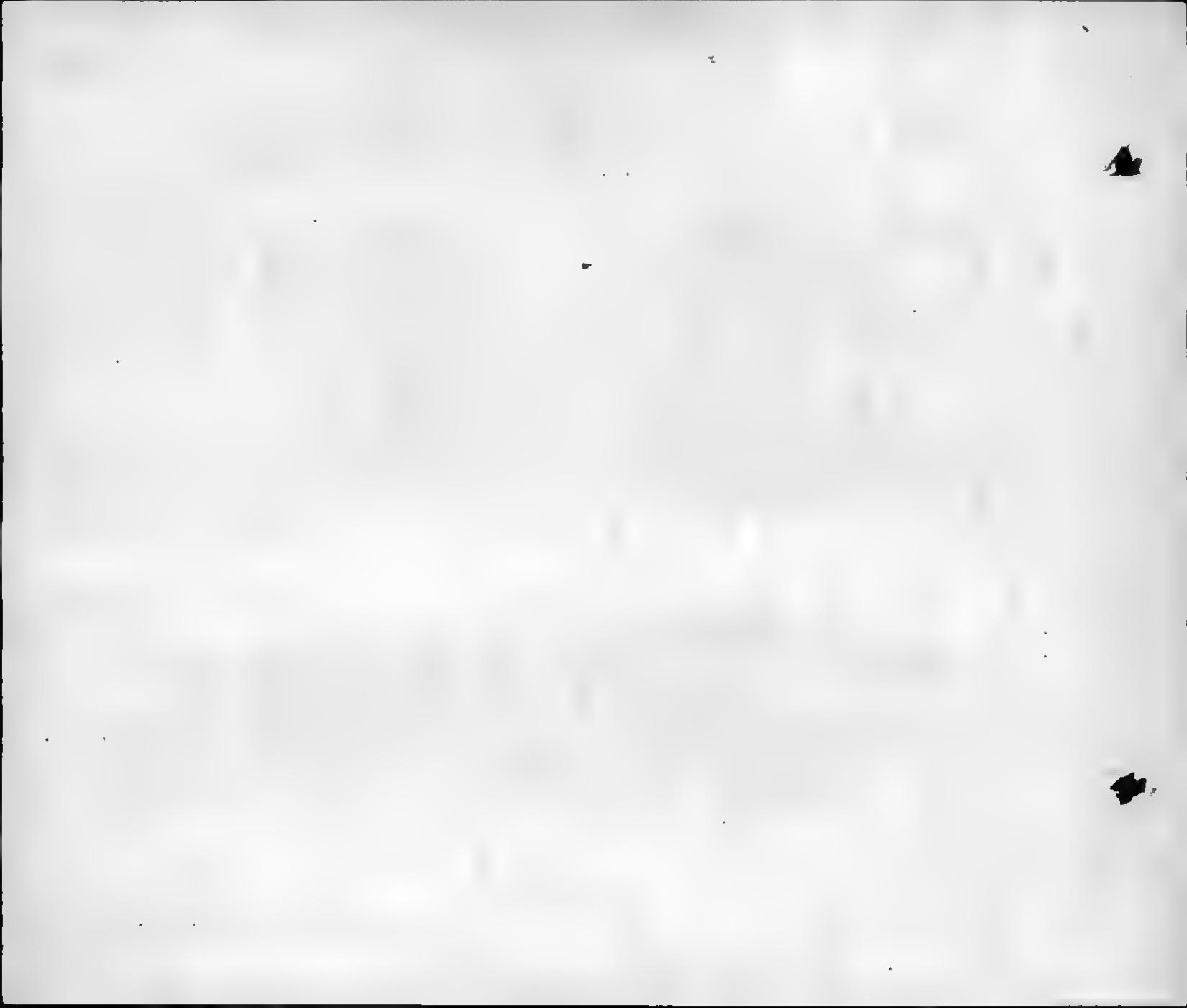
Brought in 8:15 A.M. by Rockville Rescue Squad D.O.A.

MEDICAL CERTIFICATION

5844 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 15834

1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb D.O.A.			b. COUNTY Montgomery								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban			X			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg								
3. NAME OF DECEASED (Type or print) Otis Grant Shipe			4. DATE OF DEATH May 2 1959			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 8/19/1899			9. AGE (in years at birthday) 59 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY John Hopkins Lab			11. BIRTHPLACE (State or foreign country) Bergton, Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Benjamin Shipe			14. MOTHER'S MAIDEN NAME Dora Moyer			Address								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Wife (Same as Above)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Amputation of brain stem						INTERVAL BETWEEN ONSET AND DEATH					
(b) DUE TO Fracture of skull									sudden					
(c) DUE TO Fractures of C-1 & C-2 with compression of cord														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Driver of auto involved in head on collision			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Driver of auto involved in head on collision											
20c. TIME OF INJURY 7:15 a.m. PMX	Month, Day, Year 5/2/59 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway	20f. (City or town) Gaithersburg	(County) Montg.	(State) Md.								
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Frank J. Broschart	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED May 2, 1959										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/6/59	22c. NAME OF CEMETERY OR CREMATORIAL Forest Oak Cemetery	22d. LOCATION (City, town, or county) Gaithersburg, Maryland	(State)										
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR MAY 5 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Straus											

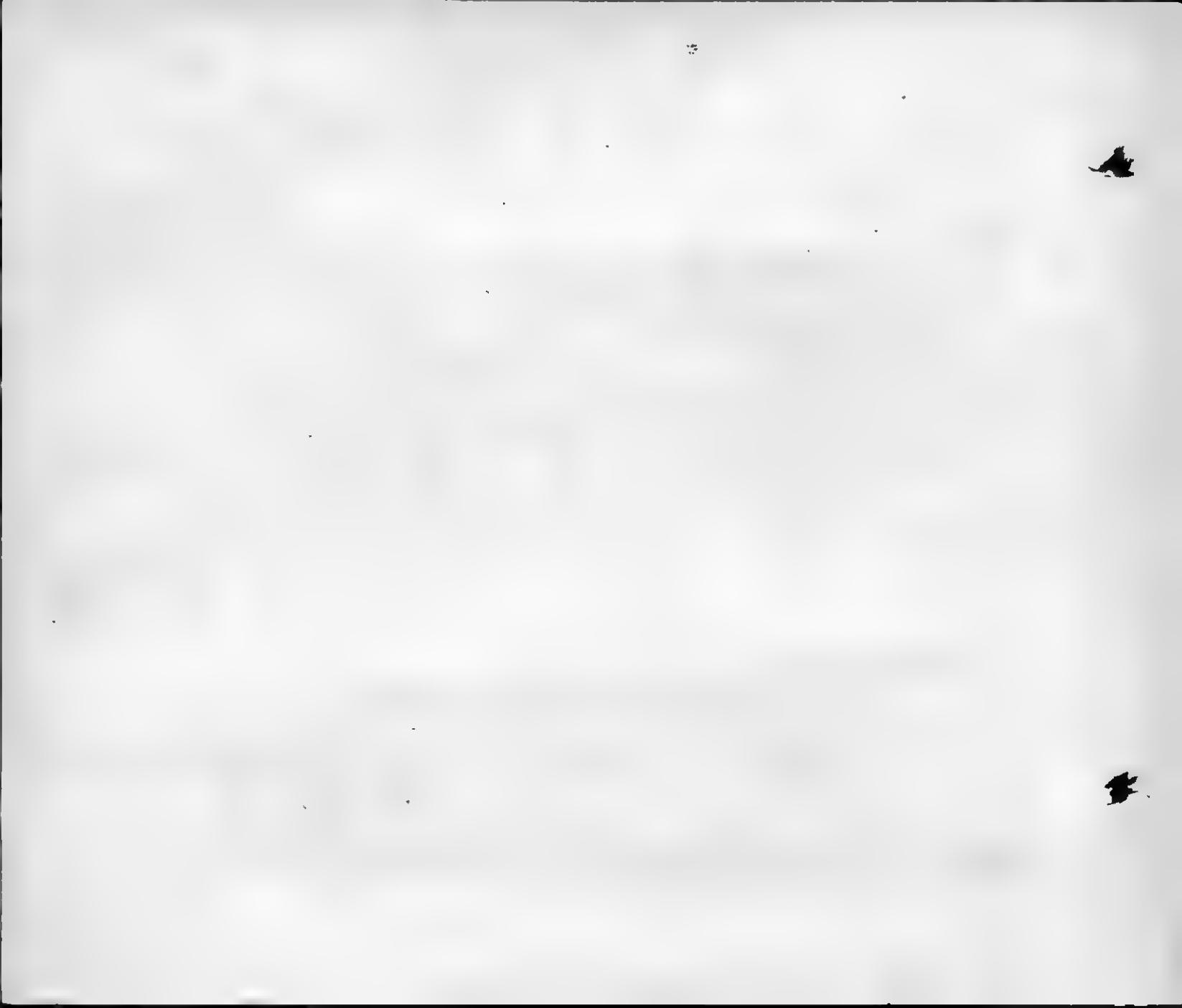


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item F-1a-62-2 5/21/59 cap 05835

5845 - CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Pen. Isd.</i> b. COUNTY <i>Passau</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda D.C.A.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Malvern</i>	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>653 Cornwall Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Anna</i>		First <i>Siegel</i>	Middle <i>Losi</i>
4. DATE OF DEATH <i>May. 14</i>	Month <i>May</i>	Day <i>14</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1882 Nov. 1894</i>
9. AGE (In years last birthday) yrs. <i>76</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Abraham Rosenblum</i>		14. MOTHER'S MAIDEN NAME <i>Pearl</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>17. INFORMANT</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		Myocardial Infarct due to Coronary Occlusion 24 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>—</i>		Coronary Arteries Sclerosis 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized Arteriosclerosis</i>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/13/59</i> to <i>5/14/59</i> , that I last saw the deceased alive on <i>5/14/59</i> , and that death occurred at <i>5:30</i> P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>John J. Curry M.D.</i>		ADDRESS (Street, city or town, state) <i>10620 Georgia Ave Silver Spring, Md</i>	
22a. BURIAL CREMATION REMOVAL (Specify) <i>Burial 5/17/1959</i>		22b. DATE THEREOF <i>5/17/1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>United Cemetery Staten Island</i>		22d. LOCATION (City, town or county) <i>Staten Island</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i>		24a. ADDRESS <i>425-9th and Ave</i>	
24b. REC'D BY REGISTRAR DATE <i>MAY 18 '59</i>		24b. REGISTRAR'S SIGNATURE <i>John J. Curry</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5723 CERTIFICATE OF DEATH

Reg. Dist. No.

05836

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince George</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		1617-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanc Hosp.</i>		d. STREET ADDRESS <i>1118 Lancaster Rd.</i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Frances</i>	4. FIRST MIDDLE <i>Isabel</i>	5. SMALL <i>Small</i>	6. DATE OF DEATH <i>5 22 1959</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>White</i>	9. AGE (In years last birthday) <i>47</i>	10. IF UNDER 1 YEAR Months <i>4</i> Days <i>7</i> Hours <i>0</i> Min. <i>0</i>	11. IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Charles Glen Heavener</i>		14. MOTHER'S MAIDEN NAME <i>Addie Sullivan</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Pt's hosp. Recoed</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Glioblastoma Multiforme (Retregtoma Grade 3)</i>		DUE TO <i>1959</i>		INTERVAL BETWEEN ONSET AND DEATH <i>47 days</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6101 New Hampshire Ave. Washington, D.C.</i>		20f. (City or town) (County) <i>D.C.</i>		(State) <i>D.C.</i>
21. I certify that I attended the deceased from <i>Jan 29, 1959</i> to <i>May 22, 1959</i> , that I last saw the deceased alive on <i>May 22, 1959</i> , and that death occurred at <i>6:35 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>6101 New Hampshire Ave. Washington, D.C.</i>		DATE SIGNED <i>5/22/59</i>		
ACTUAL SIGNATURE <i>Leo J. Schildhous</i>		PHYSICIAN'S NAME (Type) <i>Leo J. Schildhous</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/25/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>Prince Georges County, Md.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. H. Hines Co. 2901-14 st. n.w.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>5/22/59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5846 CERTIFICATE OF DEATH

Reg. Dist. No.

05837

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		b. COUNTY <u>Harford</u>		
c. LENGTH OF STAY IN 1b <u>8 ms.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>		d. STREET ADDRESS <u>None</u>		
3. NAME OF DECEASED (Type or print) <u>Grace</u>		First <u>Wilcox</u>	Middle <u>Smith</u>	
4. DATE OF DEATH <u>MAY 31 1959</u>	Month <u>MAY</u>	Day <u>31</u>	Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 9, 1876</u>	
9. AGE (In years, lost birthday) <u>83 yrs.</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>83</u>	Days <u>0</u>	Hours <u>0</u>	Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>William Littleton Smith</u>		14. MOTHER'S MAIDEN NAME <u>Suzanna Perry</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		Address <u>Asbury Methodist Home Gaithersburg</u>
17. INFORMANT <u>None</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>33IX</u> DUE TO <u>pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-20-59</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>cerebral vascular accident</u> (c) <u>arteriosclerosis</u>		5-11-59		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-3</u> , 1958, to <u>May 31</u> , 1959, that I last saw the deceased alive on <u>5-27</u> , 1959, and that death occurred at <u>12:53 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Sarah E. Glover</u> M.D. <u>10128 CEDAR LANE</u> PHYSICIAN'S NAME (Type) <u>Dr. Sarah Elizabeth Glover</u> <u>Kensington, Md</u>		ADDRESS (Street, city or town, state) <u>Kensington, Md</u> DATE SIGNED <u>5-31-59</u>		
22a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/2/59</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Green Mount Cem.</u>	22d. LOCATION (City, town, or county) <u>Balto., Md.</u>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Sisker & Sons - Balt. 17</u>	ADDRESS <u>Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Cathleen S. Turner</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

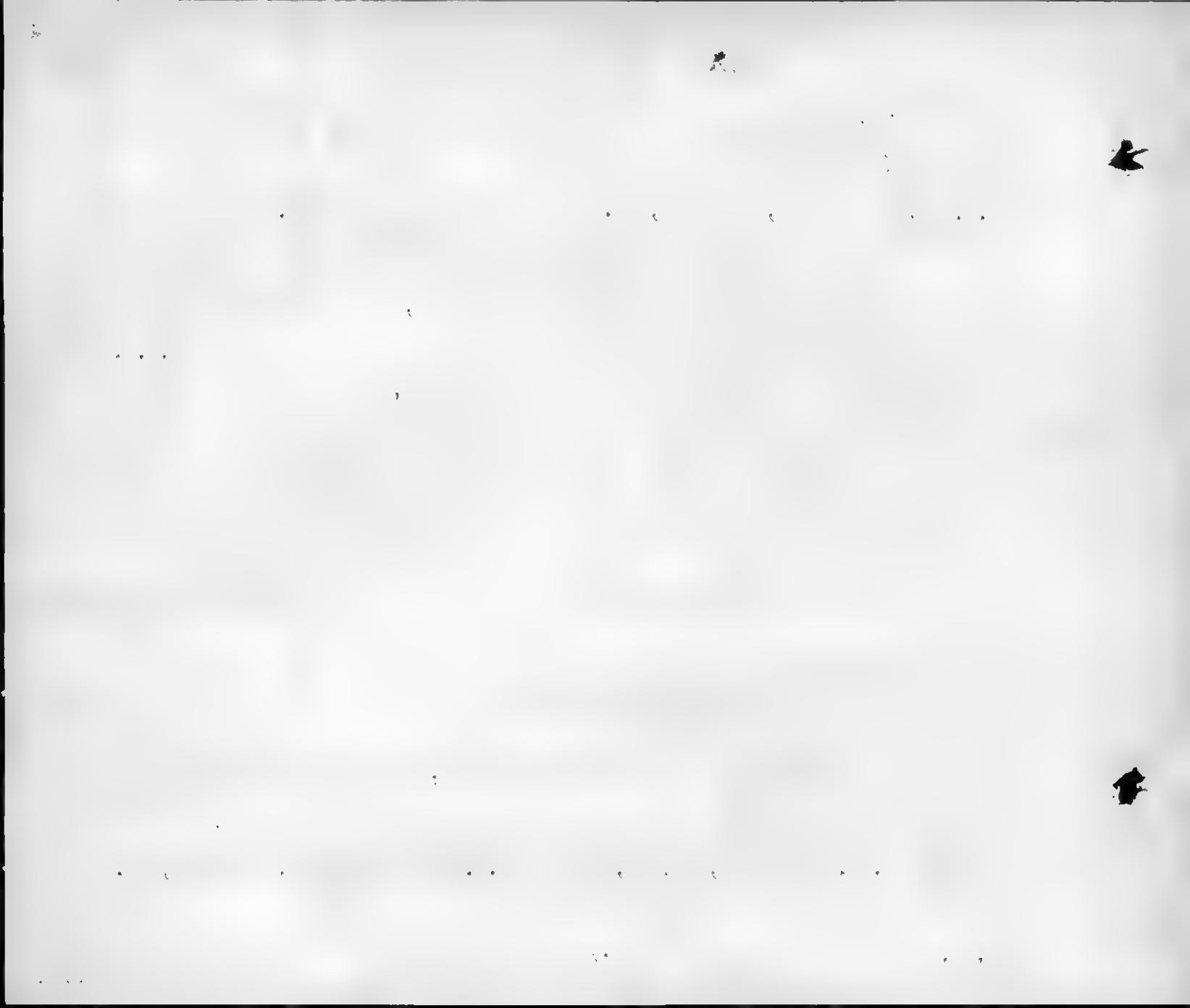
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5847 CERTIFICATE OF DEATH

Reg. Dist. No.

05838

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Missouri		b. COUNTY St Louis City	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] St Louis		62 X-3	
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3176 Gustine St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jane		First Phyllis	Middle SMITH	4. DATE OF DEATH May 21	Month Year 1959	Day	Year
5. SEX female		6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 27, 1921	9. AGE [In years last birthday] 37 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE [State or foreign country] Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert WANDER		14. MOTHER'S MAIDEN NAME Norine O'BRIAN		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 500-18-0971		17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 195.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH 10 mo.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from April 21, 1959, to May 21, 1959, that I last saw the deceased alive on May 21, 1959, and that death occurred at 7:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE George F. Sengstack		ADDRESS (Street, city or town, state) U.S.N.H. Bethesda, Md.				DATE SIGNED	
PHYSICIAN'S NAME (Type) G. F. SENGSTACK, LT, MC, USN		U.S. NAVAL HOSPITAL, BETHESDA, MD.					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 May 1959		22c. NAME OF CEMETERY OR CREMATORIUM Calvary Cemetery		22d. LOCATION (City, town, or county) St Louis	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY		ADDRESS 1557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DAMAY 2 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



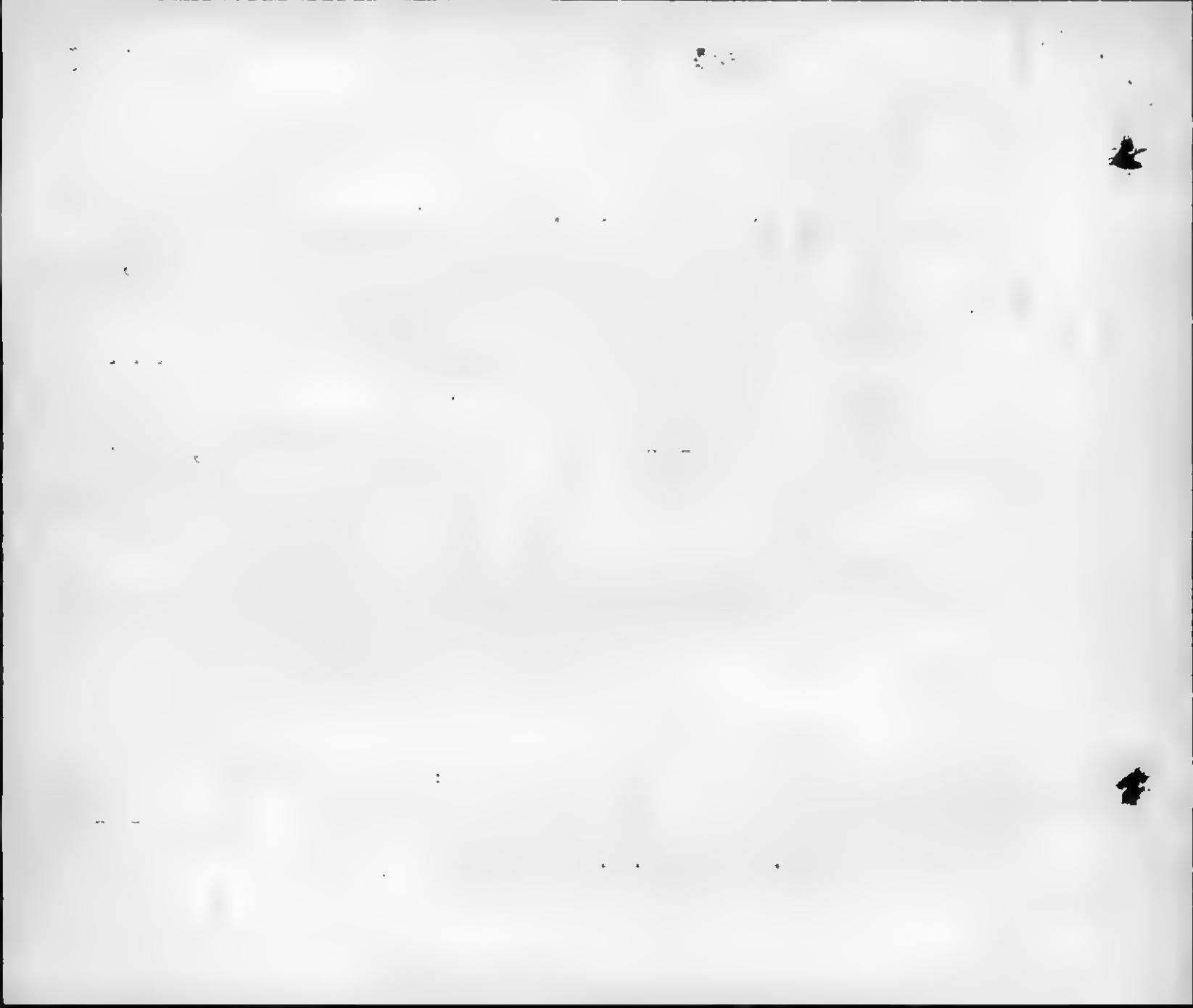
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5843 CERTIFICATE OF DEATH

Reg. Dist. No.

05839

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 14 days		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE New Jersey		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark		d. STREET ADDRESS 590 North Sixth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) Shirley		First May	Middle Smith	4. DATE OF DEATH May 10, 1959	Month May	Day 10	Year 1959		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 15, 1933	9. AGE (In years last birthday) 25	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Joseph Smith		14. MOTHER'S MAIDEN NAME Mae O'Neill		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 135-26-9626		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7/15/59		Cardiac arrest		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) NOXOC 30		Ventricular septal defect with congestive failure and intrathoracic hemorrhage (post- operative)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 1P		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) None		(County) N	(State) N
21. I certify that I attended the deceased from April 26 , 1959, to May 10 , 1959, that I last saw the deceased alive on May 10 , 1959, and that death occurred at 2:18a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5-10-59									
ACTUAL William P. Cornell		M.D.		National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) William P. Cornell, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 5/13/59		22b. DATE THEREOF 5/13/59		22c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven		22d. LOCATION (City, town, or county) None		(State) N	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kline		ADDRESS 1400 16th Street, N.W.		24a. REC'D BY REGISTRAR DATE MAY 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

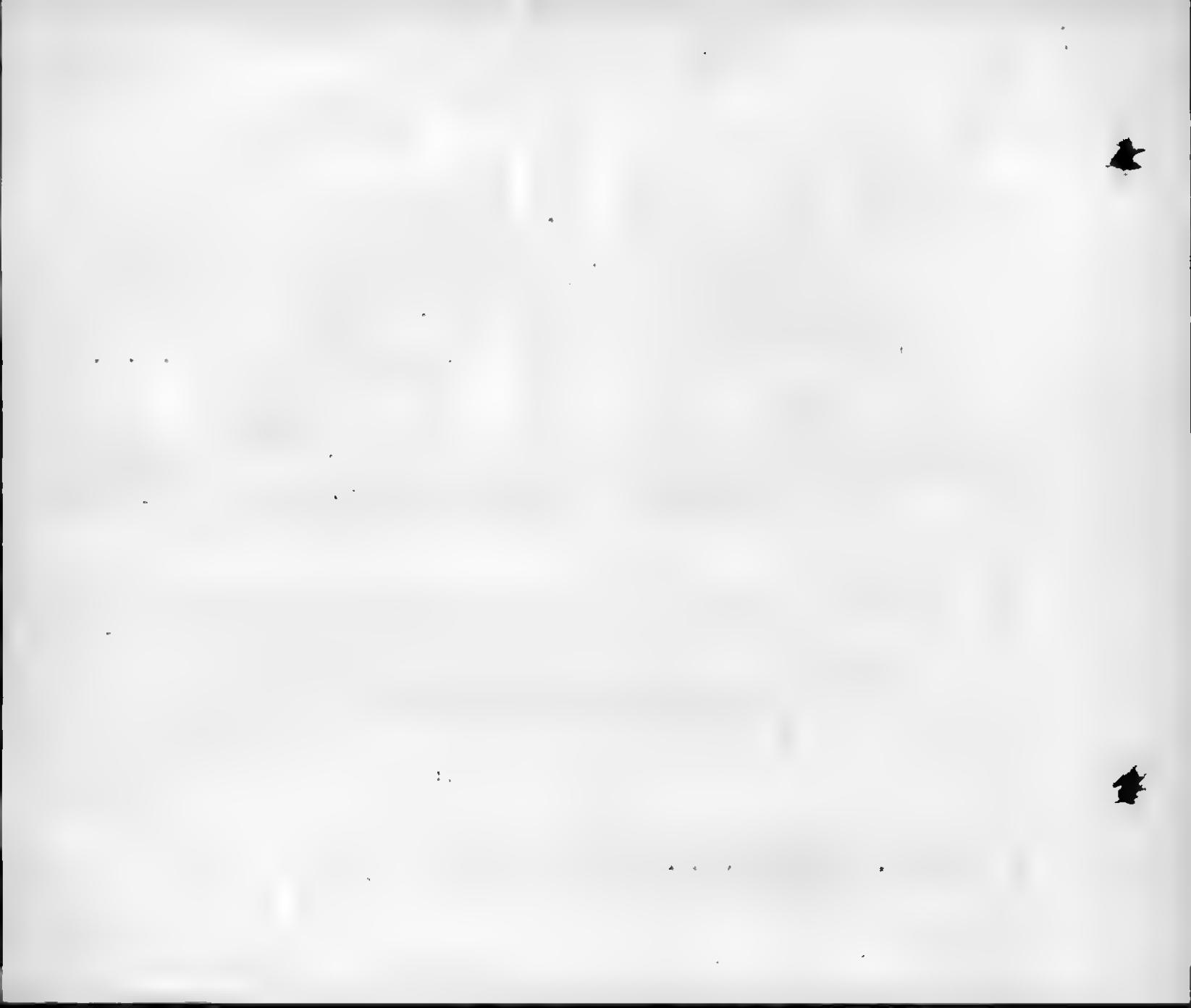


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5849 CERTIFICATE OF DEATH

Reg. Dist. No. 015841

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Pennsylvania</u>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>		d. STREET ADDRESS <u>75 x 3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>6962 Ogontz Avenue</u>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Tillie</u>		First <u>(none)</u>	Middle <u></u>	Last <u>Snyderman</u>	4. DATE OF DEATH <u>May 11, 1959</u>	Month <u>May</u>	Day <u>11</u>	Year <u>1959</u>	
S. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <u>October 8, 1890</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR IF UNDER 24 HRS Months <u></u>			Yrs. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator's Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ladies' Clothing</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13. FATHER'S NAME <u>Gabriel Snyderman</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Forman</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Not available</u>		17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Malignant Synovium Metastatic to Lungs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)									
DUE TO (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Philadelphia</u>		(County) <u>Philadelphia</u>	(State) <u>PA</u>
21. I certify that I attended the deceased from <u>May 6</u> , 19 <u>59</u> , to <u>May 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 11</u> , 19 <u>59</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <u>The Clinical Center</u>	
ACTUAL SIGNATURE <u>G. Richard Lee, M.D.</u>		M.D.						DATE SIGNED <u>5/12/59</u>	
PHYSICIAN'S NAME (Type) <u>G. RICHARD LEE, M.D.</u>		The Clinical Center National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/13-1959</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Har Hebo</u>		22d. LOCATION (City, town, or county) <u>Philadelphia</u>		(State) <u>PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldsberg Funeral Home</u>		ADDRESS <u>Washington DC</u>		24a. REC'D BY REGISTRAR <u>MAY 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



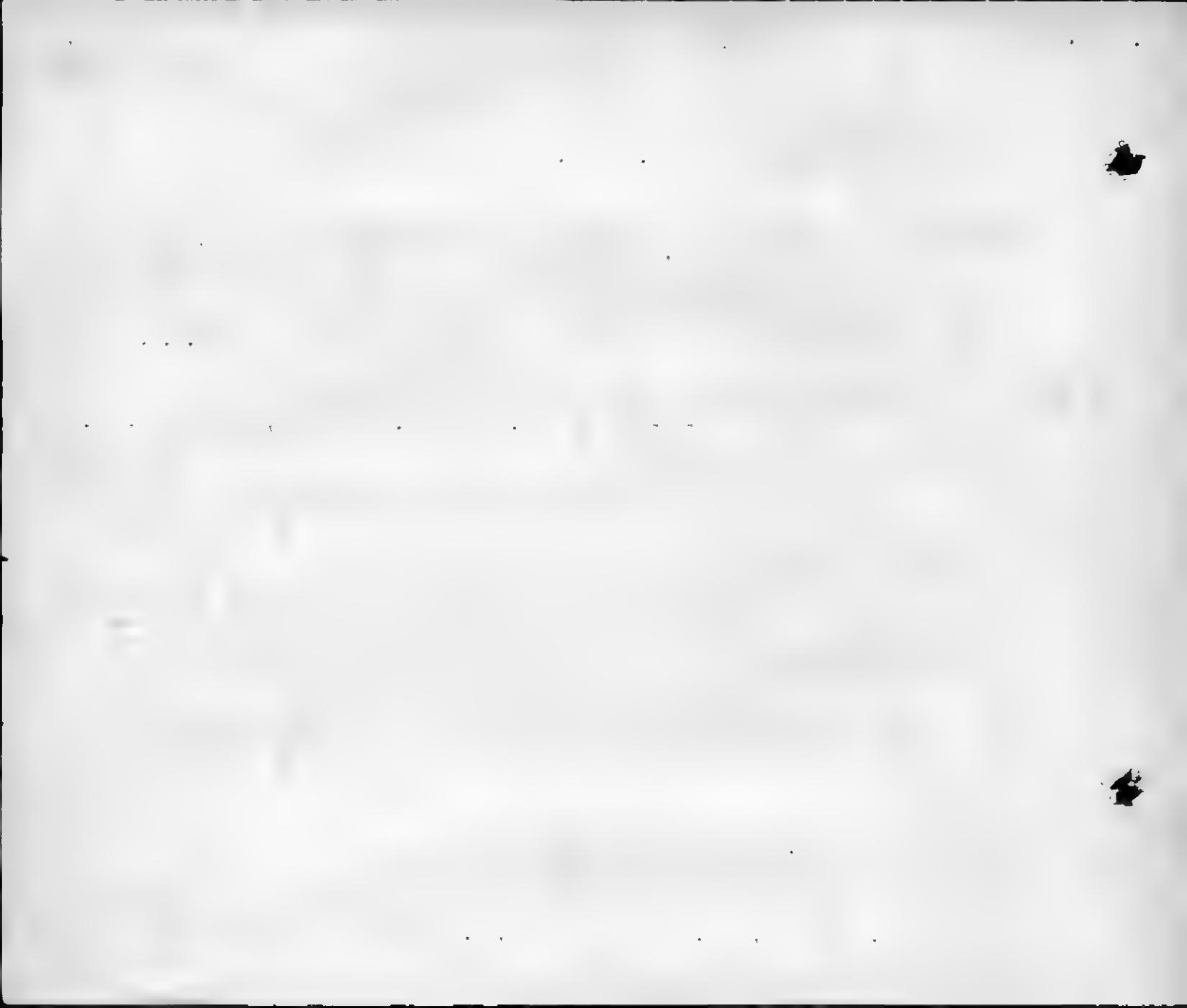
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5850 CERTIFICATE OF DEATH

Reg. Dist. No. 05841

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSBURG		c. LENGTH OF STAY IN 1b Appr. 4 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSBURG		f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Henry J. Stanowsky		First	Middle	Last	4. DATE OF DEATH Month May	Day 20	Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/87	9. AGE (In years last birthday) 72	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER (retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JULIUS HENRY STANOWSKY		14. MOTHER'S MAIDEN NAME MARY LOUISE REX								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-07-4241 B		17. INFORMANT Mrs. Minnie C. Stanowsky, Clarksburg, Md.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		DUE TO Anteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 10 years						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		(c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Montgomery, Md.		(County)	(State)	
21. I certify that I attended the deceased from 10/15/58 to 5/20/59 , that I last saw the deceased alive on 5/18/59 , and that death occurred at 8:10 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Montgomery, Md.				DATE SIGNED 5/20/59
ACTUAL SIGNATURE <i>James D. Kerr</i>		M.D.								
PHYSICIAN'S NAME (Type) JAMES D. KERR										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/23/59		22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND				
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAY 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause				

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

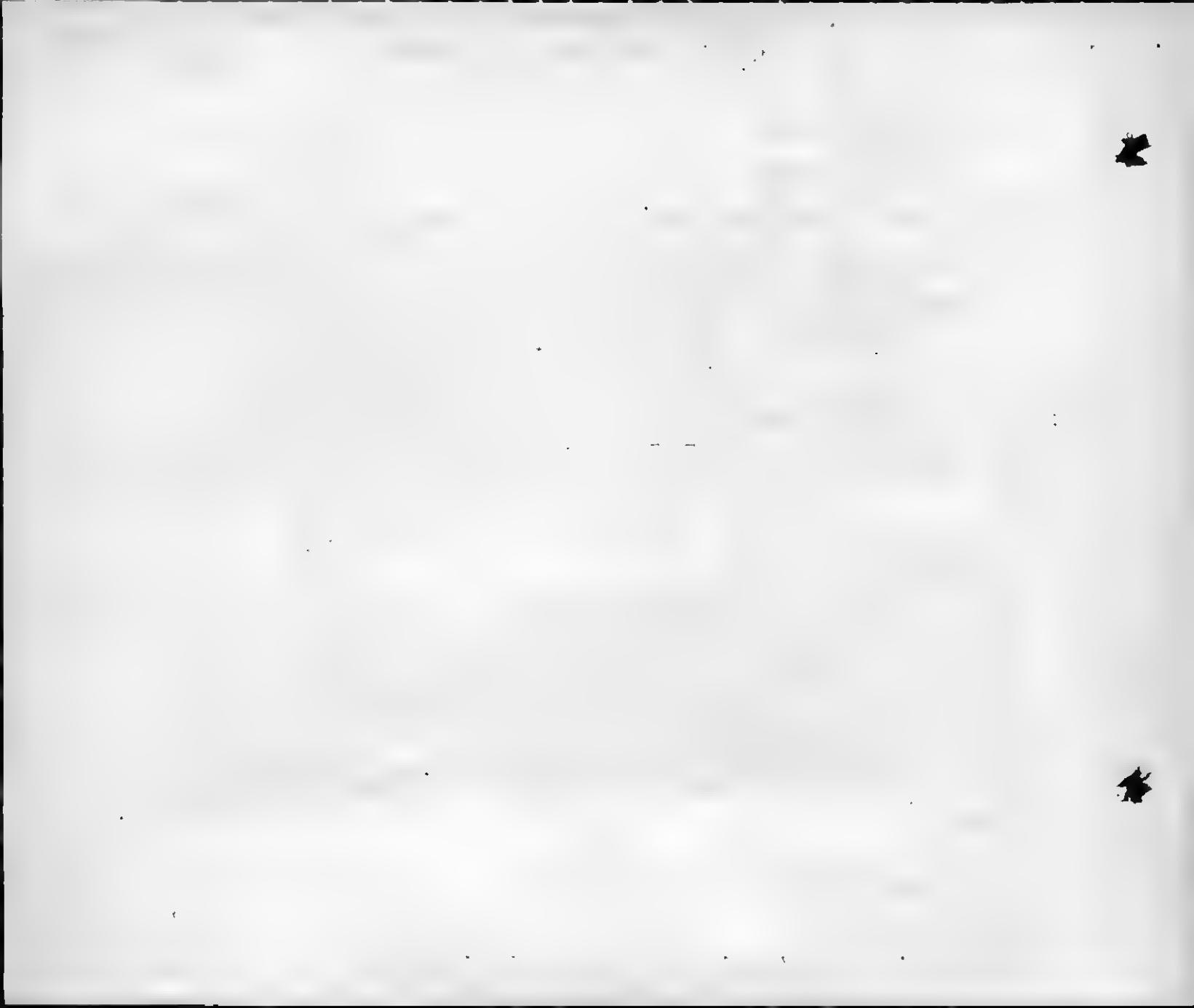
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5851 CERTIFICATE OF DEATH

Reg. Dist. No. 05842

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oney</i>		c. LENGTH OF STAY IN TB <i>1 yr 5 mo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Chronic Hosp-</i>		e. STREET ADDRESS <i>17505-Brookville Road</i>	
3. NAME OF DECEASED (Type or print)	First <i>Miller</i>	Middle <i>B. Stevenson</i>	Last 4. DATE OF DEATH <i>May 17 1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 28-1880</i>
9. AGE (In years lost birthday) <i>78 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>7</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Anson & Gilker Co.</i>	11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Christopher S. Stevenson</i>	
14. MOTHER'S MAIDEN NAME <i>Sara</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service <i>No</i>	
16. SOCIAL SECURITY NO. <i>579-01-1781</i>		17. INFORMANT <i>John R. Blake</i>	Address <i>1732 Taylor St. N.W. Washington D.C.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute bronchitis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i>Chronic Glomerulonephritis</i>		7 yrs	
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 6</i> , 1958, to <i>17 May</i> , 1959, that I last saw the deceased alive on <i>13 May</i> , 1959, and that death occurred at <i>7:00 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Bosley Ziegler M.D.</i>		ADDRESS (Street, city or town, state) <i>Oney, Md.</i> DATE SIGNED <i>17 May 59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL <i>5/20/59</i>		22b. DATE THEREOF <i>5/20/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>PARKLAWN CEMETERY</i>
22d. LOCATION (City, town, or county) <i>MONTGOMERY COUNTY, MARYLAND</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziegler</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 19 '59</i>	
ADDRESS <i>SILVER SPRING, MD.</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5852 CERTIFICATE OF DEATH

05843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 96 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 76 Forrester Street, S. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Francis Glonleau Steward, Jr.		First	Middle	Last	4. DATE OF DEATH May 12, 1959	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 20, 1915	9. AGE (In years lost birthday) 44 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Apartment Upkeeping		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY: U. S. A.		
13. FATHER'S NAME John Steward		14. MOTHER'S MAIDEN NAME Mary E. Shaw						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) Yes		16. SOCIAL SECURITY NO. 577-24-6486		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 days				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Hypertension		Years				
DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) FT. MYER, VIRGINIA		(County) WASHINGTON (State) VIRGINIA
21. I certify that I attended the deceased from February 5, 1959 to May 12, 1959 , that I last saw the deceased alive on May 12, 1959 , and that death occurred at 5:34 AM , from the causes and on the date stated above				ADDRESS (Street, city or town, state)		DATE SIGNED 5/12/59		
ACTUAL SIGNATURE Edgar Haber		M.D. The Clinical Center The National Institutes of Health Bethesda 14, Maryland						
PHYSICIAN'S NAME (Type) EDGAR HABER, M.D.								
22a. BURIAL CREMATION OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-15-59		22c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) FT. MYER, VIRGINIA		
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Haas		ADDRESS 414-15TH ST. S. E. WASH. D. C.		24a. REC'D BY REGISTRAR Arthur S. Haas		24b. REGISTRAR'S SIGNATURE Arthur S. Haas		
				DATE MAY 14 '59				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

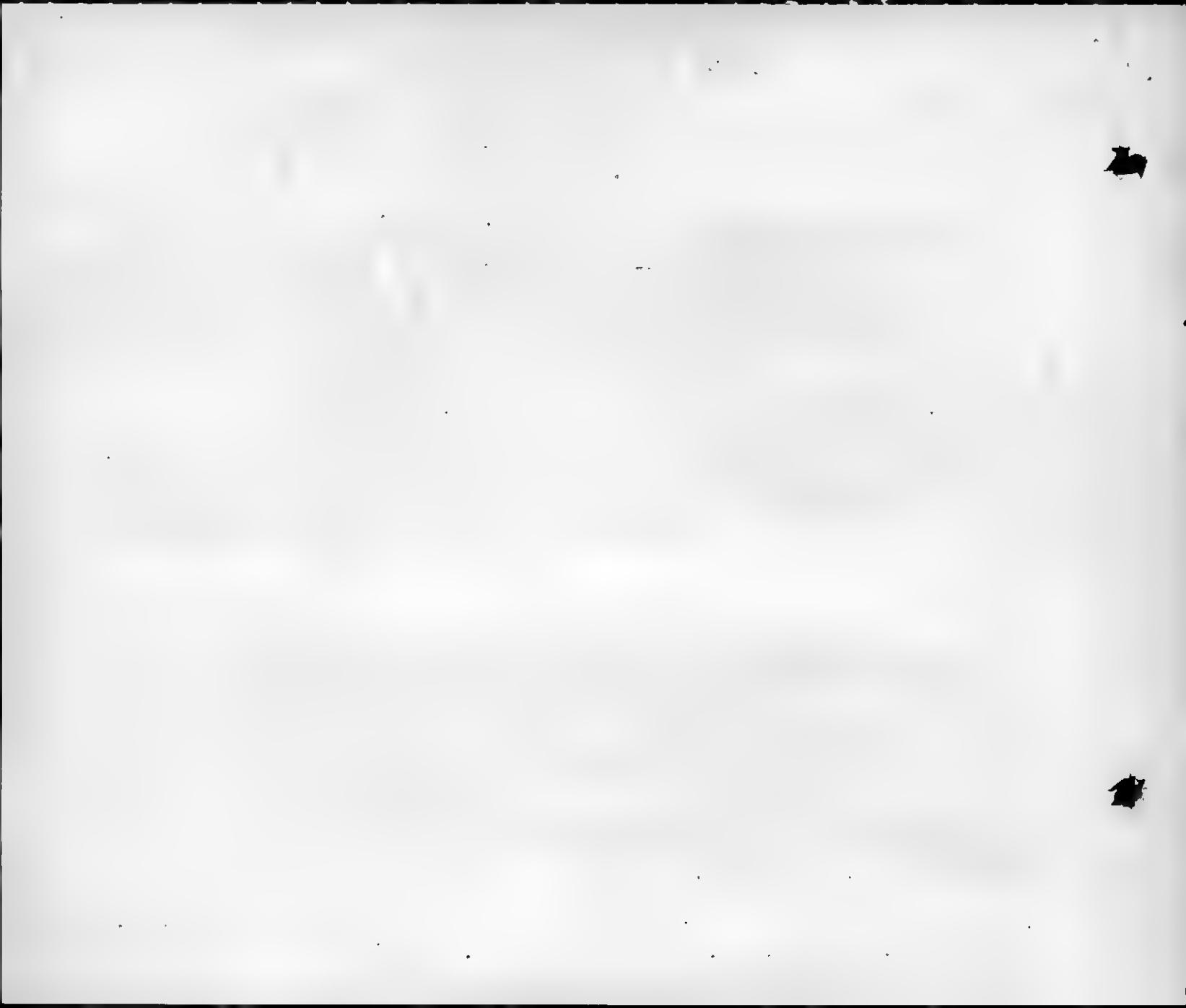
5853 CERTIFICATE OF DEATH

Reg. Dist. No.

05844

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 10 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS RT. #1 HOMECREST ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First	Middle --	Last STRICKLAND	4. DATE OF DEATH MAY 24	Month 19	Day 59
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 24, 1959		9. AGE (In years from birthdate) yrs 10	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME HAROLD WADE STRICKLAND		14. MOTHER'S MAIDEN NAME ELLEN MARY SMITH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Address OLNEY, MARYLAND	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from MAY 24 , 1959, to MAY 24 , 1959, that I last saw the deceased alive on MAY 24 , 1959, and that death occurred at 12:35 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) OLNEY, MARYLAND		DATE SIGNED 5/25/59					
ACTUAL SIGNATURE <i>Richard A. Yates</i>		NAME (Type) R. A. YATES, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/27/59		22c. NAME OF CEMETERY OR CREMATORIUM GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER B. HUMPHREY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAY 27 '59		24b. REGISTRAR'S SIGNATURE Carlo S. Frane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5854 CERTIFICATE OF DEATH

05845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Montgomery Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ropine Nursing Home; River Road		d. STREET ADDRESS 38 Milmarson Pl. N.W.	
e. LENGTH OF STAY IN 1b 4 months		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie E. Taylor		4. DATE OF DEATH MAY 51 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 Jan 1859	
9. AGE (In years last birthday) 100 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME UNKNOWN	
14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT R.M. STRICKROTT, 9919 Logan Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Vascular Disease DUE TO 42 a.i Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Generalized Arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 Jan 1959, to 21 May 1959, that I last saw the deceased alive on 29 May 1959, and that death occurred at 6:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE W.F. Cresswell, Jr. M.D. DATE SIGNED 2029 Q St., N.W. 5-31-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-3-59	
22c. NAME OF CEMETERY OR CREMATORIUM Takoma Creek		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME		ADDRESS WASHINGTON D.C.	
24a. REC'D BY REGISTRAR DATE JUN 3 '59		24b. REGISTRAR'S SIGNATURE Oscar S. Knob	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

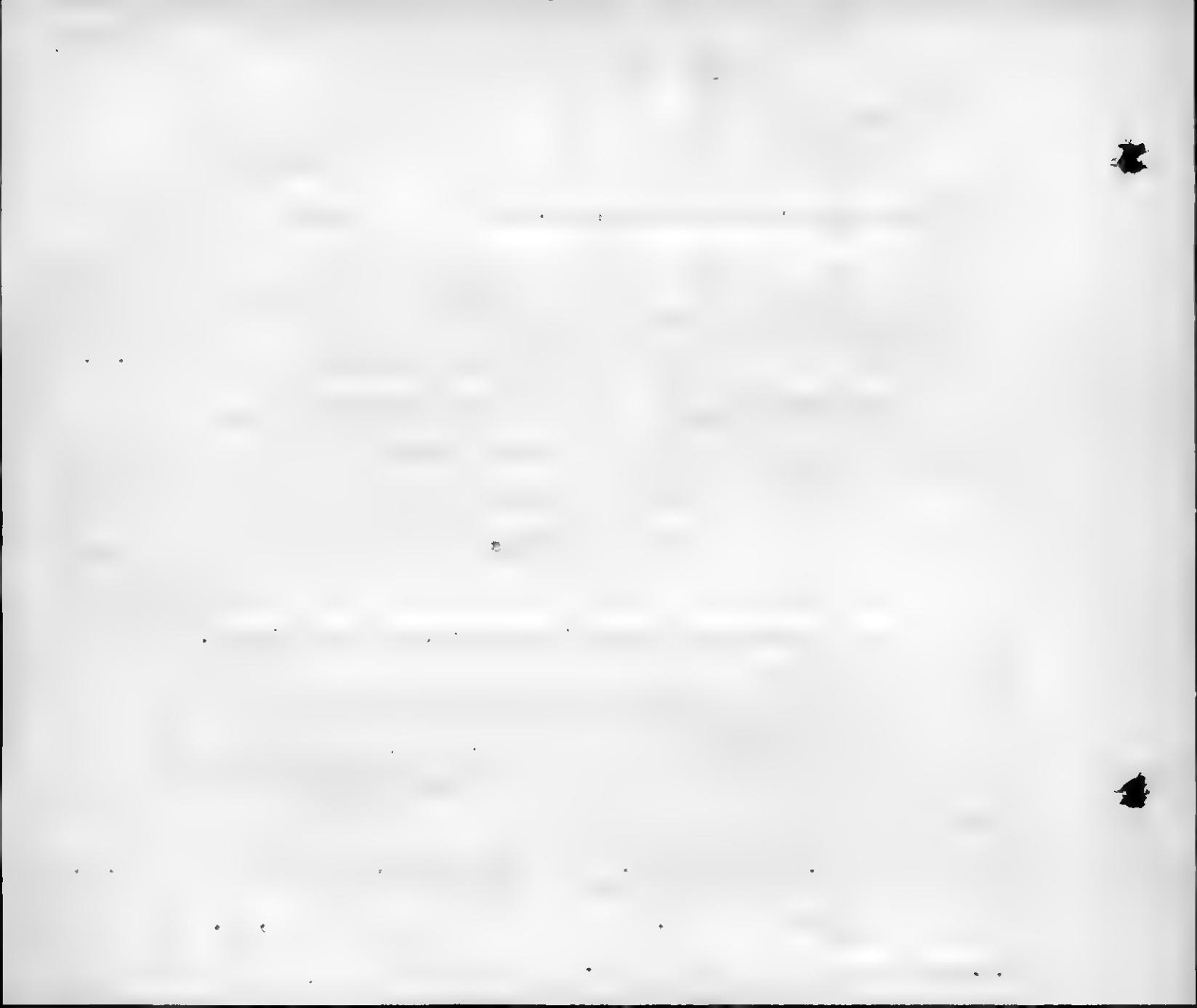
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5855 CERTIFICATE OF DEATH

05846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS Route #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Julia		First Julia		Middle Holton		4. DATE OF DEATH Month May 13		Day Year 19 59	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-28-88		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME Isaac Iglehart		14. MOTHER'S MAIDEN NAME Josephine Stansfield							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Ruptured Thoracic aneurysm OF AORTA				INTERVAL BETWEEN ONSET AND DEATH 12 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive arteriosclerotic cardiovascular renal disease.						5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Clarksville, Maryland		(County) Howard (State) Md.			
21. I certify that I attended the deceased from JULY , 1947, to MAY 12 , 1959, that I last saw the deceased alive on MAY 12 , 1959, and that death occurred at 11:45 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles S. Whitaker</i> , M.D.						ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED 5.13.59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/15/59		22c. NAME OF CEMETERY OR CREMATORIAL Mt. View		22d. LOCATION (City, town, or county) Alpha, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham		ADDRESS Ellicott City, Md.		24a. REC'D BY REGISTRAR MAY 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

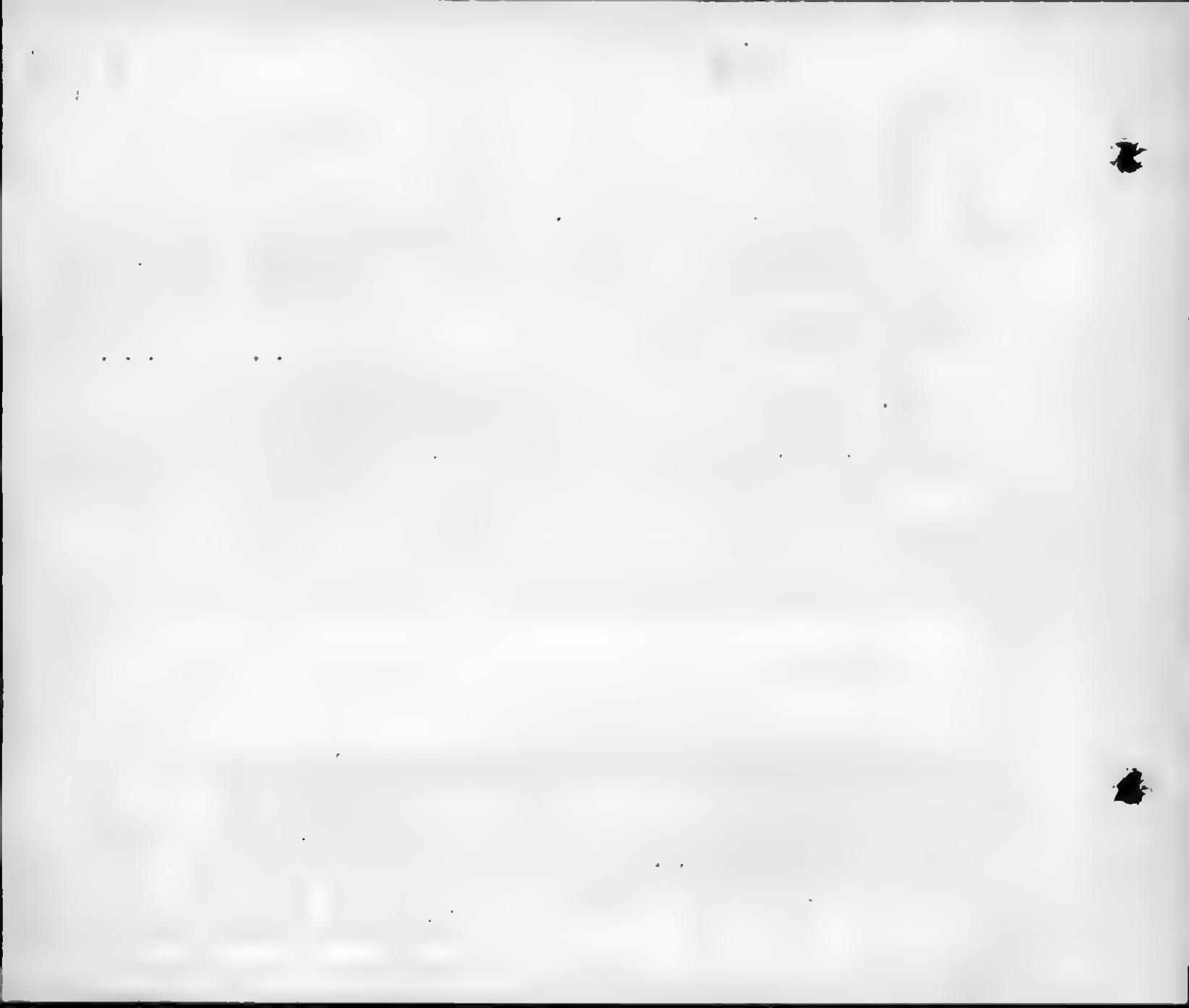
5856

CERTIFICATE OF DEATH

Reg. Dist. No.

05847

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 37 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Fairfax	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Herndon		d. STREET ADDRESS Route #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sharon		First Sharon	Middle Marie	Last Thorpe	4. DATE OF DEATH May 7, 1959	Month May	Day 7	Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 22, 1954	9. AGE (In years last birthday) 4 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0		Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Herman O. Thorpe		14. MOTHER'S MAIDEN NAME Carrie Holdaway							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO ACUTE LYMPHOCYTIC LEUKEMIA		INTERVAL, BETWEEN ONSET AND DEATH 6 1/2 mos					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Herndon		(County) Virginia	(State) MD
21. I certify that I attended the deceased from March 31, 1959 to May 7, 1959 , that I last saw the deceased alive on May 7, 1959 , and that death occurred at 9:15a M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>G. Richard Lee</i>	M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 5/7/59				
PHYSICIAN'S NAME (Type) G. RICHARD LEE, M.D.		National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 10, 1959		22b. DATE THEREOF May 10, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Chesnut Grove Cemetery		22d. LOCATION (City, town, or county) Herndon, Virginia		(State)*	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Berkley Green</i>		ADDRESS Herndon, Va.		24a. REC'D BY REGISTRAR May 12 '59		24b. REGISTRAR'S SIGNATURE <i>John S. Kline</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05848
215

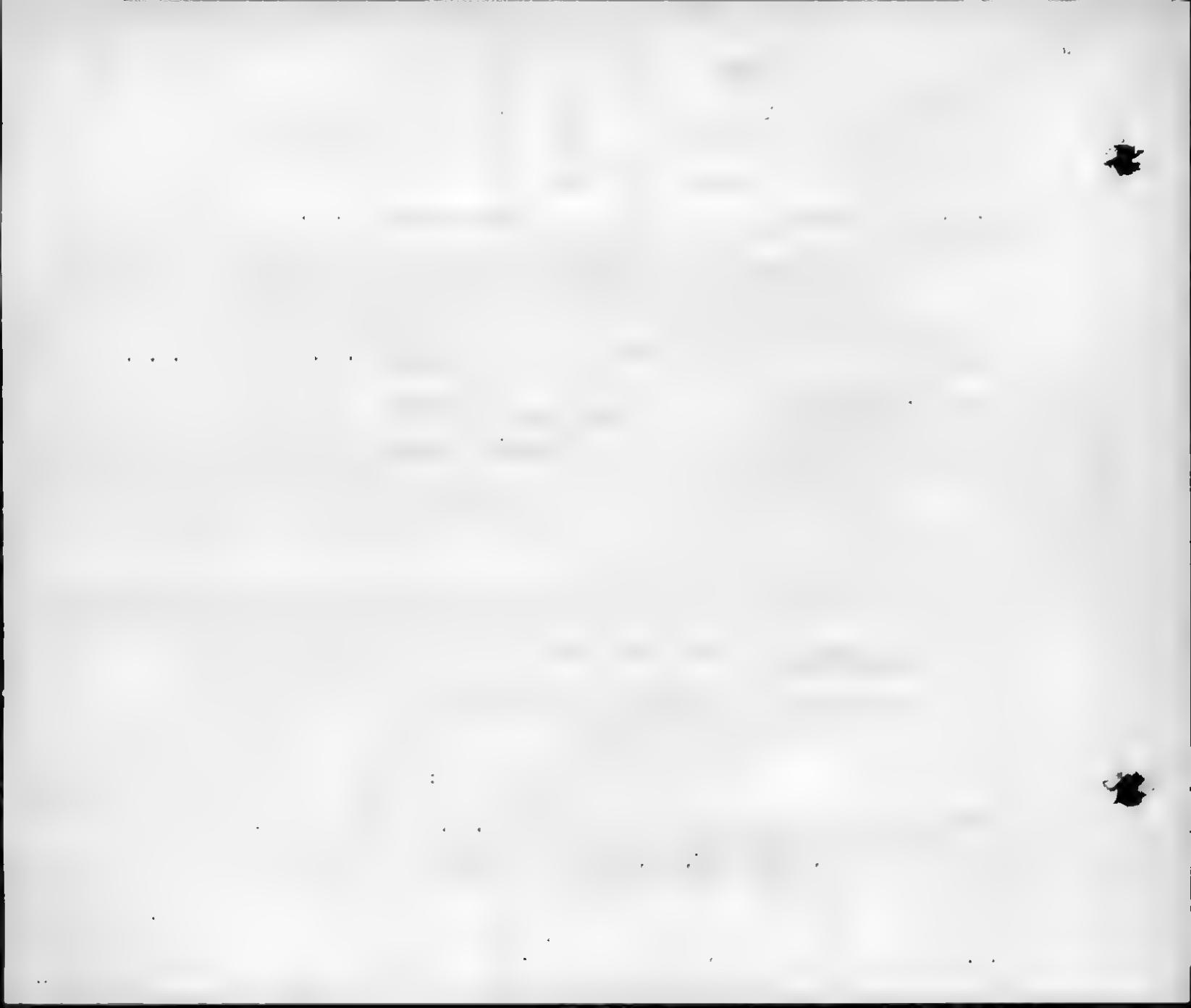
CERTIFICATE OF DEATH

Reg. Dist. No.

5857

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rurra)		c. LENGTH OF STAY IN lb 36 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 300 T Street, N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Vernon		First Lawson		Middle UPDEGROVE		4. DATE OF DEATH May 9 1959	Month Day Year
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-8-17	
9. AGE (In years lost birthday) 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		11. KIND OF BUSINESS OR INDUSTRY Food Store		12. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Frank E. UPDEGROVE		14. MOTHER'S MAIDEN NAME Hazel SENNE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) Yes		16. SOCIAL SECURITY NO. 1940-1945	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <i>Metastatic Carcinomatosis</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. Naval Hospital, NNMC		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3, 1959 to May 9, 1959 , that I last saw the deceased alive on May 8, 1959 , and that death occurred at 3:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>John W. Troy</i>		22. ADDRESS (Street, city or town, state) Bethesda 14, Maryland		23. DATE SIGNED 5-9-59			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 5-13-59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Funeral Home, 1400 Chapin St., NW		24a. ADDRESS Wash., DC		24b. REC'D BY REGISTRAR DATE MAY 12 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

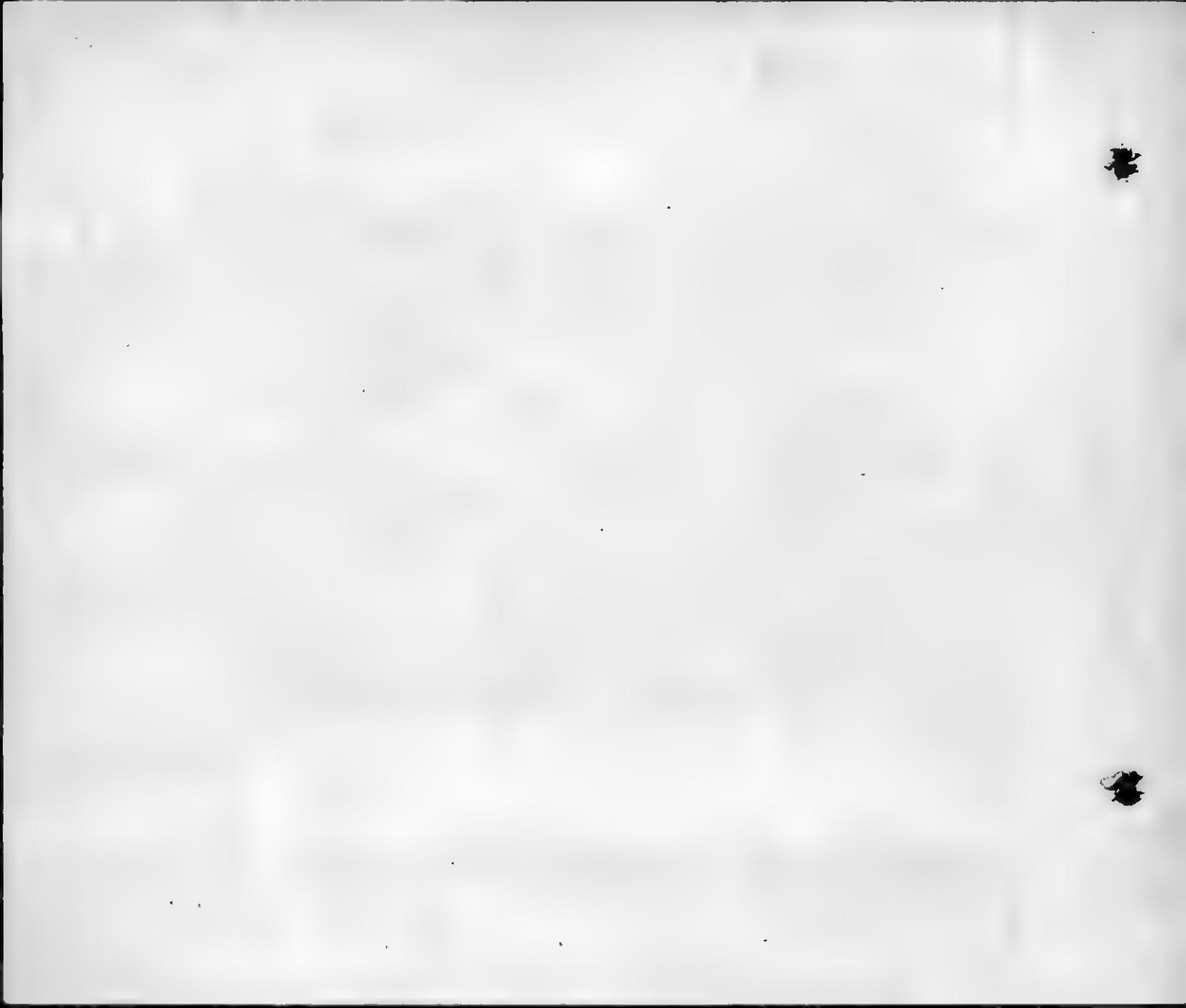
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the attending physician. After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 05849

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		5853 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Chevy Chase</i>		c. LENGTH OF STAY IN 1b <i>1</i>		b. COUNTY <i>MD</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8911 1/2 - Montgomery Ave.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Chevy Chase</i>		c. STREET ADDRESS <i>8911 1/2 Montgomery Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Herbert E Wade</i>		4. DATE OF DEATH <i>5 - 1 - 1959</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 20 1884</i>	9. AGE (In years last birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Thomas J Wade</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Phillips</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <i>225-05-4815</i>		17. INFORMANT <i>Mrs Franklin Beavers - same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		<i>Congestive heart failure</i> <i>Coronary Occlusion</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>None</i>			
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/18/59</i> , 19 <i>59</i> , to <i>5/1/59</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5/1/59</i> , 19 <i>59</i> , and that death occurred at <i>12:23 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>John B. Umhoe</i>		M.D. <i>8825 Penn Ave.</i> <i>5/1/59</i>			
PHYSICIAN'S NAME (Type) <i>John B. Umhoe</i>		Chevy Chase 15 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-4-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt Olivet</i>	
22d. LOCATION (City, town, or county) <i>Washington D.C.</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home - Washington D.C.</i>		ADDRESS <i>Lee Funeral Home - Washington D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 6 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur & Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05850

5859

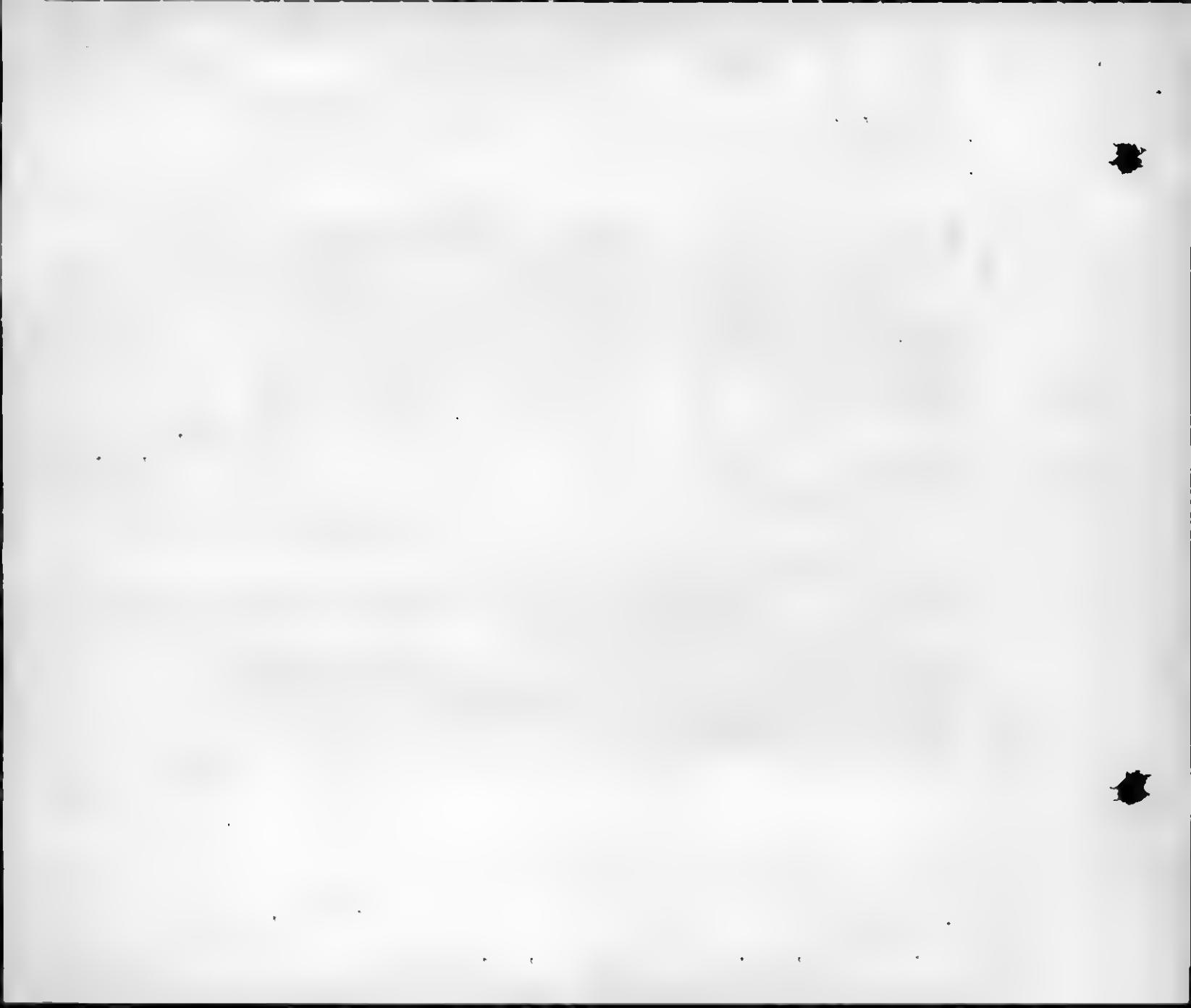
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens</i>		d. STREET ADDRESS <i>3312 University Blvd, W+</i>		d. DATE OF DEATH <i>1954 4 1954</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Robertta Lee Wandling</i>		First <i>Robertta</i>	Middle <i>Lee</i>	Last <i>Wandling</i>	Month <i>Apr</i>	Day <i>3</i>	Year <i>1954</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 3 XXXXX 1871</i>	9. AGE (In years last birthday) <i>88 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Adjudicator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Govt</i>		11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>JOHN WANDLING</i>		14. MOTHER'S MAIDEN NAME <i>JANE EVANS</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Eliz. Smith</i>		Address <i>3605 Dupont Ave., Seneca, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) <i>Cerebral vascular accident</i>		DUE TO (b) <i>Apr 11 month</i>					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Adenocarcinoma of Uterus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>10110 Georgia Ave</i>		(County) <i>M.D.</i>	(State) <i>Silver Spring, Md.</i>
21. I certify that I attended the deceased from <i>Apr</i> , 1954, to <i>May 4</i> , 1954, that I last saw the deceased alive on <i>May 4</i> , 1954, and that death occurred at <i>12:36 PM</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>10110 Georgia Ave</i>							
DATE SIGNED <i>5/4/59</i>							
ACTUAL SIGNATURE <i>John Lawrence Avery</i>		22. MEDICAL CERTIFICATION					
PHYSICIAN'S NAME (Type) <i>John Lawrence Avery</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS. & BURIAL 5/6/59</i>					
22b. DATE THEREOF <i>5/6/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ELMWOOD CEMETERY</i>		22d. LOCATION (City, town, or county) <i>OWENSBORO, KENTUCKY</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>MAY 8 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Carroll & Turner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

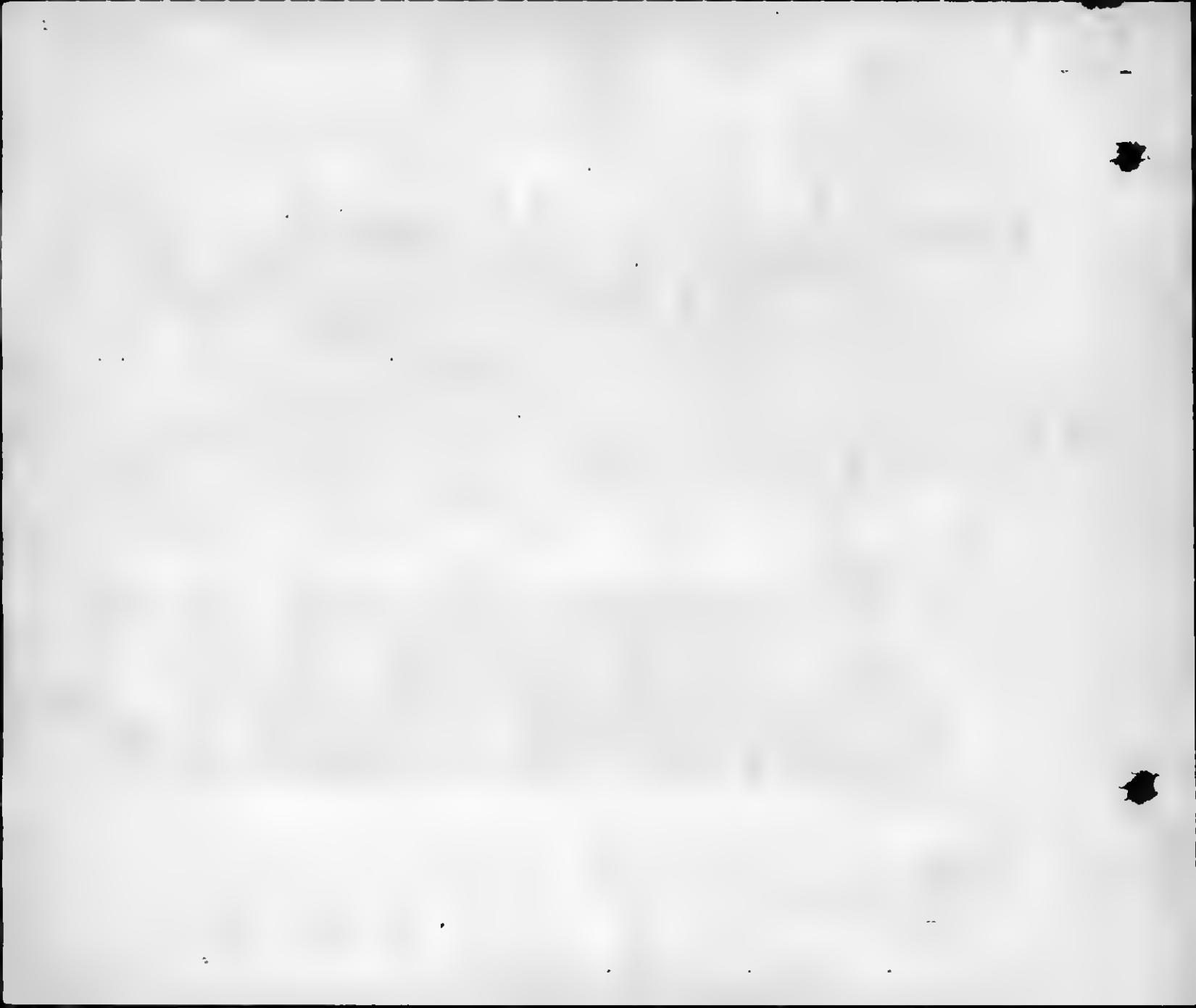
05851

Reg. Dist. No.

5860

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery MARYLAND		a. STATE Conn. b. COUNTY New Haven	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 21 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meriden	
d. STREET ADDRESS 560 New Hanover Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Everett	Middle A.	Last Ward
4. DATE OF DEATH	Month May	Day 21	Year 19 59
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 30, 1899
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
59 yrs.	10	21	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Machinist	
11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fredrick Ward		14. MOTHER'S MAIDEN NAME (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 042-14-7768	
17. INFORMANT Son in Law (Robert Roosa)		Address 4210 South End Rd. Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 <u>myocardial infarction</u> INTERVAL BETWEEN ONSET AND DEATH 7 hrs.			
DUE TO (b) <u>Coronary Thrombosis</u> ?			
DUE TO (c) <u>Arterio sclerosis</u> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> OF DEATH.		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19	
		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans		22b. DATE THEREOF 5/21/59	
22c. NAME OF CEMETERY OR CREMATORIUM Walnut Grove Cem.		22d. LOCATION (City, town, or county) Meriden, Connecticut (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS	
		24a. REC'D BY REGISTRAR	
		24b. REGISTRAR'S SIGNATURE Arthur S. Tamm	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05852

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		5861		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>RURAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		d. STREET ADDRESS <i>Piney Meeting House Rd.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		e. STREET ADDRESS <i>Piney Meeting House Rd.</i>		d. STREET ADDRESS <i>Piney Meeting House Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Jesse GARNETT</i>		First	Middle	4. DATE OF DEATH <i>1951</i>	Month <i>5</i>	Day <i>30</i>	Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 10 1882</i>	9. AGE (In years lost birthday) yrs. <i>77</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		11. KIND OF BUSINESS OR INDUSTRY <i>Farming.</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
14. FATHER'S NAME <i>Harrison</i>		15. MOTHER'S MAIDEN NAME <i>Ward</i>		16. SOCIAL SECURITY NO. <i>217036-6714</i>		17. INFORMANT <i>Ouida J. Ward</i>	Address <i>Same wife.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>526 X</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.</i>		DUE TO <i>Diarrhea, etc.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>				
(b) <i>Diarrhea, etc.</i>		(c) <i>Convalescence</i>				<i>7 days</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>injury, etc.</i>								
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Rockville</i>	(County) <i>Maryland</i>	(State) <i>Md.</i>			
21. I certify that I attended the deceased from <i>4/1/57</i> to <i>5/1/57</i> , that I last saw the deceased alive on <i>5/1/57</i> , and that death occurred at <i>Rockville</i> , Md., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Rockville, Md.</i> DATE SIGNED <i>5/30/57</i>										
ACTUAL SIGNATURE <i>Stephen N. Jones</i>		PHYSICIAN'S NAME (Type) <i>Stephen N. Jones</i>		22d. LOCATION (City, town, or county) (State) <i>Darnestown, Maryland</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/2/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Darnestown Cemetery</i>		24a. REC'D BY REGISTRAR DATE JUN 2 '59				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. This bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 FilmG2+3 6-2-59 et

05853

5862

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED							
COUNTY		MONTGOMERY		STATE		COUNTY MONTGOMERY					
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)					
TOWN Cedar Grove		80 Years		X Cedar Grove		Cedar Grove					
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)							
R.F.D. Germantown				R.F.D. Germantown							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH May 22 1959							
Female		White		Watkins		9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.					
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)		8. DATE OF BIRTH 1873 July 27 1972 85 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
Housewife				Widowed		Maryland					
13. FATHER'S NAME				14. MOTHER'S M AIDEN NAME							
William Mullinix				Elizabeth Bowman							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS							
No		None		Mable A. Tregoning Same As 2							
18. MEDICAL CERTIFICATION <i>Interiosclerotic cardiovascular disease 10 years</i>								INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>None</i>		IMMEDIATE CAUSE (A)		DUE TO							
ANTECEDENT CAUSE(S)		DUE TO									
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B)									
STATING UNDERLYING CAUSE LAST.		DUE TO									
(C)											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)		(State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <i>31/10/1958</i> to <i>5/7/3/1959</i> , that I last saw the deceased alive on <i>5/7/2/1959</i> , and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above.								ADDRESS (Street, city, town, state)			
SIGNATURE <i>James J. Kerr</i>								DATE SIGNED <i>5/7/3/1959</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county)		(State)			
Burial		May 25 59		Salem Methodist		Cedar Grove		Md.			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS					
DATE MAY 27 '59		Signature		Roy W. Barber		Laytonsville, Md.					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05854

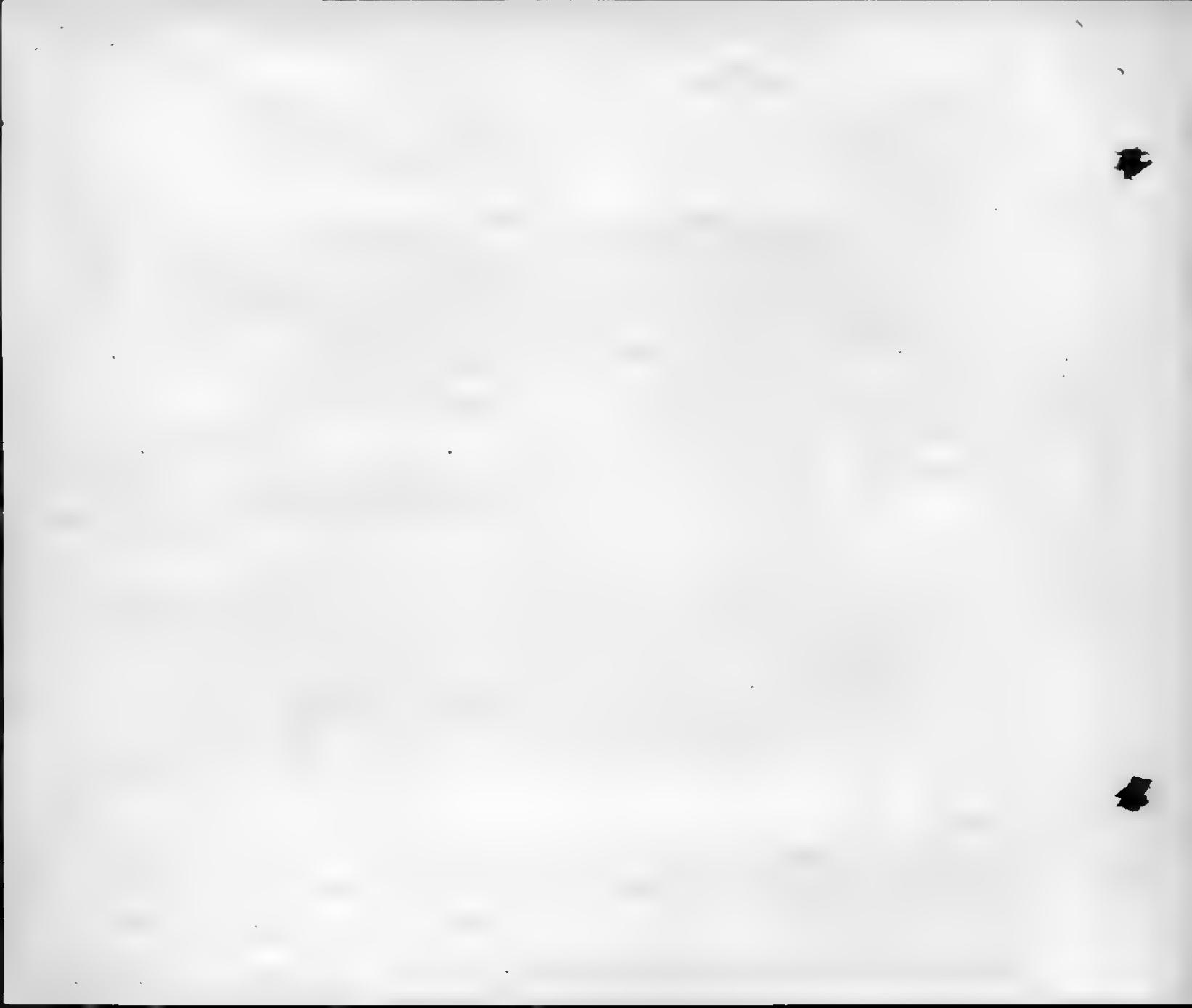
CERTIFICATE OF DEATH

Reg. Dist. No.

5863

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Hunting Hill		c. LENGTH OF STAY IN lb 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Hunting Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GRACE		First B.	Middle WHALEN	4. DATE OF DEATH May 17, 1959	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 11, 1877	9. AGE (In years lost birthday) 82 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		10c. BIRTHPLACE (State or foreign country) Maryland	
11. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Hamilton Crown		14. MOTHER'S MAIDEN NAME Sarah Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT William M. Whalen-Rockville, Md.-Son	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Circumstances of right breast, with metastasis to liver & lungs (This patient refused surgery)		INTERVAL BETWEEN ONSET AND DEATH 3 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity & hypertension - 5 years.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 17	
(County) 17		(State) MD			
21. I certify that I attended the deceased from 1915 to 1949 that I last saw the deceased alive on May 17, 1949 , and that death occurred at 17 from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 N. Sarrett Ave. - 17/18959					
ACTUAL SIGNATURE W. A. Linthicum		DATE SIGNED 5/18/59			
PHYSICIAN'S NAME (Type) William A. Linthicum					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20-59		22c. NAME OF CEMETERY OR CREMATORIAL Rockville Cemetery	
22d. LOCATION (City, town, or county) Rockville, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 19 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5864

CERTIFICATE OF DEATH

Reg. Dist. No.

05855

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b First Middle Last		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D.C.		b. COUNTY					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 3913 Ingomar St N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Beulah		First Middle Last Whitaker		4. DATE OF DEATH May 16		Month	Day	Year					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1868		9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookeeper (retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Al. Whitaker		14. MOTHER'S MAIDEN NAME Hester Trundle		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO No		17. INFORMANT Mrs Samuel Huey-3913-Ingomar St. N.W.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 11.20.0		DUE TO Myocardial Involution, acute		(Niece)		INTERVAL BETWEEN ONSET AND DEATH 10 years					
		Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) Arterio-sclerotic heart disease, advanced		3 yrs.							
				DUE TO (c) Arterio-sclerotic, general advanced		10 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. ————— p. m. —————		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. —————		20f. (City or town) M.D. —————		(County) M.D. —————		(State) M.D. —————			
21. I certify that I attended the deceased from 1953 to May 16 , 1959, that I last saw the deceased alive on 5/12/1959 , and that death occurred at 215 p.m. from the causes and on the date stated above.													
ADDRESS (Street, city or town, state) 3921 11th St. N.W. Washington, D.C.													
DATE SIGNED 5/16/59													
ACTUAL SIGNATURE Stewart Clapp		PHYSICIAN'S NAME (Type) Stewart Clapp		ADDRESS Washington, D.C.		22d. LOCATION (City, town, or county) Beallsville, Md.		(State)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Monacacy		22d. LOCATION (City, town, or county) Beallsville, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE MAY 19 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Krause							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by physician or attending physician.
 TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, removal, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05856

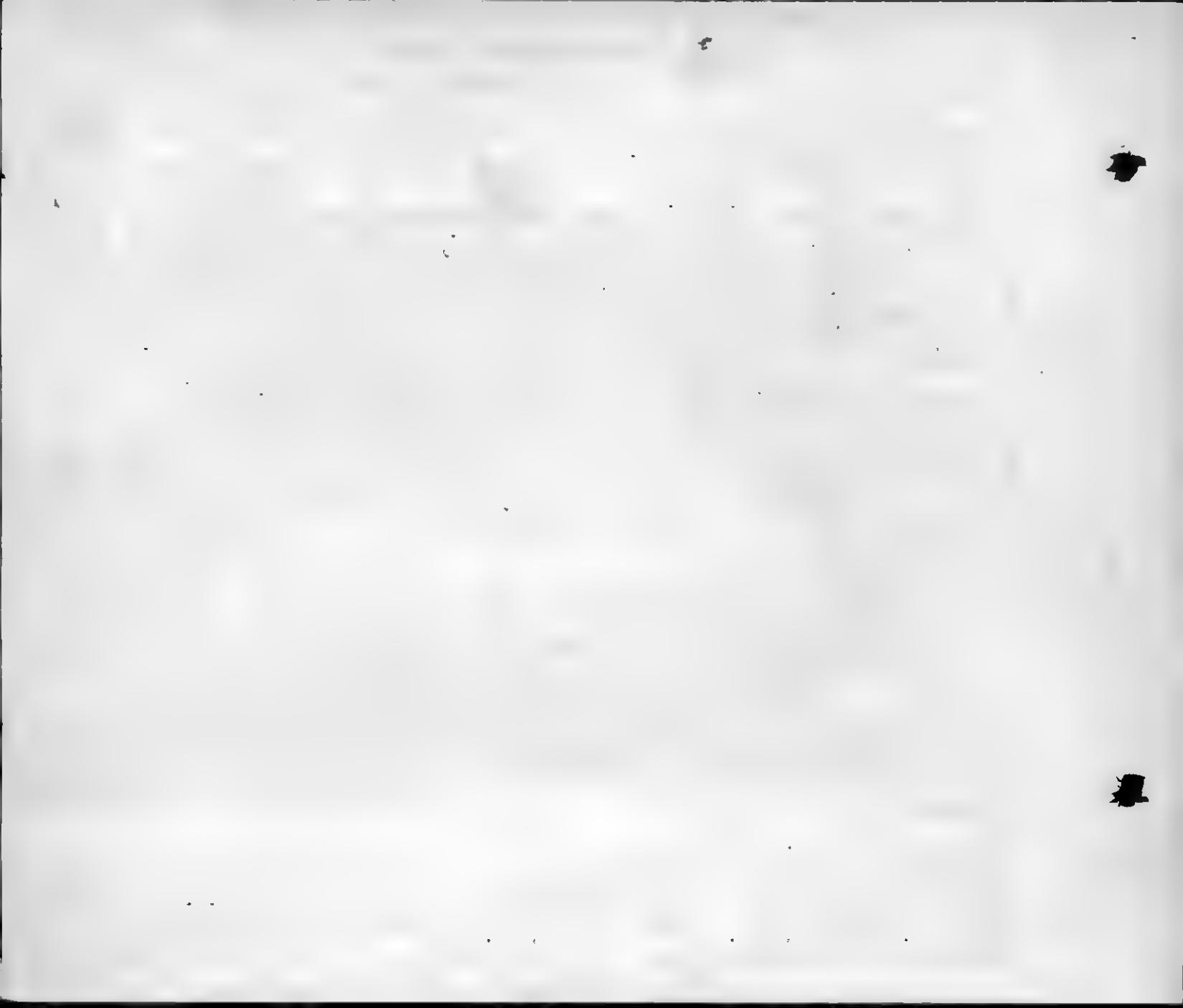
Williams

5724

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 16 <i>3 wks.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash Subd Hosp.</i>		d. STREET ADDRESS <i>7914 13th St N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Williams</i>		4. DATE OF DEATH <i>May 14</i>		Month <i>5</i>	Day <i>14</i>
5. SEX <i>M.</i>		6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-24-82</i>	9. AGE (In years last birthday) <i>76 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Devine Schenck</i>		14. MOTHER'S MOTHER'S NAME <i>MARY Moerder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Hosp Records.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage from esophageal varices</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9 days</i>	
(b) <i>Hepatomegaly</i>				1. years	
(c) <i>Esophageal varices, sigmoid colon.</i>				2 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1 July</i> , 1958, to <i>14 May</i> , 1959, that I last saw the deceased alive on <i>13 May</i> , 1959, and that death occurred at <i>1:50 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>Seruch T. Kimble</i>		M.D. <i>929 Faraday Drive, S. S., Md. 14 May 59</i>			
PHYSICIAN'S NAME (Type) <i>SERUCH T. KIMBLE</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>5/16/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ROCK CREEK CEMETERY</i>	
22d. LOCATION (City, town, or county) <i>WASHINGTON, D.C.</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>MAY 18 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kimble</i>		DATE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5725 CERTIFICATE OF DEATH

05857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		b. COUNTY <u>Montgomery</u>	
c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>		d. STREET ADDRESS <u>8119 Flower Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Thornton Macpherson Woodall</u>		4. DATE OF DEATH <u>5/18</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/8/91</u>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years lost birthday) yrs. <u>67</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plastering Contractor - self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas J. Woodall</u>		14. MOTHER'S MAIDEN NAME <u>Louella Wedding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W. I</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Pf's Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u>			
DUE TO <u>Congestive heart failure</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Arteriosclerosis - hypertension</u>			
DUE TO (c) <u>old</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>5118</u>	
(County)		(State)	
21. I certify that I attended the deceased from <u>4/58</u> , 19 <u>58</u> , to <u>5/18/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/17/59</u> , 19 <u>59</u> , and that death occurred at <u>7349</u> M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <u>Bernard J. Walsh</u> M.D. DATE SIGNED <u>5/18/59</u>			
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>May 20 1959</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>4 Lincoln Memorial Bladensburg</u>	
22d. LOCATION (City, town, or county) <u>Baltimore</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Watters - 254 Carroll St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 21 1959</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur Watters</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05858

5865 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	c. LENGTH OF STAY IN 1b 1/2 hr.										
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION SUBURBAN HOSPITAL	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 26 Rockville 1502 GRANDIN AVE.										
3. NAME OF DECEASED (Type or print) WALLIS	First C	Middle C	Last WRIGHT	4. DATE OF DEATH MAY 13 1959	Month MAY	Day 13	Year 1959				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 30, 1898	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INTER'L REPRSENTATIVE ELEC. WORKERS	10b. KIND OF BUSINESS OR INDUSTRY INTER'L BRO. MOAD	11. BIRTHPLACE (State or foreign country) HULL, ENGLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME FRANCIS WRIGHT	14. MOTHER'S MAIDEN NAME CHARLOTTE WALLIS	INFORMANT MARTHA L. WRIGHT (Wife) AS. ABOVE	Address AS. ABOVE								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. 1917-1919	17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 HOURS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)								
21. I certify that I attended the deceased from 8-2 , 1958, to 5-13 , 1959, that I last saw the deceased alive on 5-13 , 1959, and that death occurred at 635 M , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Washington D.C.	DATE SIGNED Philip R. James				
ACTUAL SIGNATURE Philip R. James	PHYSICIAN'S NAME (Type) Philip R. James	22a. BURIAL, CREMATION, REMOVAL (Specify) Removal						22b. DATE THEREOF 5/16/59	22c. NAME OF CEMETERY OR CREMATORIAL Logan Cemetery	22d. LOCATION (City, town, or county) Logan, Utah	(State)
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.						ADDRESS 14th St. N.W. Washington 9, D.C.	24a. REC'D BY REGISTRAR MAY 14 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

